Adapting Parent-Child Interaction Therapy to Train Wilderness Therapy Camp Staff

Brian M. Syzdek

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Psychology

June 17, 2014

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2014

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Acknowledgements

I would like to thank my family, friends, and professors. I would especially like to thank my beautiful wife, Sue. Thanks for your support.

Abstract

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Wilderness therapy camps have been found to be effective for treating a number of youth issues and for generally improving youth functioning. In addition, wilderness therapy camps appear to address current treatment needs, including reducing stigma in treatment and providing other benefits, such as physical and social health advantages. However, wilderness therapy camps currently lack systematic training for staff that has been deemed efficacious. Parent-child interaction therapy (PCIT), an evidence-based therapy (EBT) which has been used for children with a variety of issues and backgrounds and in diverse settings, has proven useful for reducing child problematic behaviors. Efforts have been made to expand the use of PCIT in a variety of settings, with promising results.

This dissertation proposed to describe how PCIT might be adapted to train wilderness therapy camp staff in evidence-based methods for working with youth, especially those with mental health needs, such as behavioral issues. The literature concerning PCIT and wilderness therapy camps was reviewed. A needs assessment was conducted, consisting of interviews with key informants, experts in the field of wilderness therapy, PCIT, and training methods. Based on information obtained, a full program for training camp staff, called Counselor-Camper Interaction Training (CCIT) was created. Finally, a proposal to evaluate the efficacy of this program was put forth. As part of the proposed evaluation, a financial assessment was conducted on the program, and the results were presented.

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Chapter 1: Background of the Problem

Youth Issues

In the United States, there are a number of psychosocial issues that can be problematic for youth. These issues can impact children and adolescents' development in different ways throughout their lives and can have lasting implications. It is important to understand the interaction between these problematic issues and the various systems within young people's lives, as well as the effect of these factors on development. People involved in the care of youth should make efforts to reduce the occurrence of these problems and promote restorative interventions in the event that development is impacted. Among these psychosocial issues are emotional and mental health disorders and child behavioral disorders.

In a given year, on average in the United States, 20% of children and adolescents have mental health problem symptoms or signs, and approximately 5% have "extreme functional impairment" (U.S. Department of Health and Human Services [HHS], 1999). In a cost-benefit analysis, researchers calculated that the annual cost of child and adolescent mental health disorders in the United States is $247 billion (National Research Council, 2009). This includes costs for treatment, loss in productivity, social costs, and incarceration. Not included are the detrimental psychological effects on youth and their families and communities. In terms of school effects, the ramifications of these mental health issues include: a drop-out rate among youth with mental health disorders which is twice that of those without them (Lehr, Johnson,

Bremer, Cosio, & Thompson 2004), lower grades and test scores among youth with behavioral difficulties and inattention (Fleming et al., 2005), and more restricted settings and special-education accommodations among youth with untreated mental health needs (Bruns et al., 2004). Behavioral disorders were found to be the most common reason for referral for mental health services (Achenbach & Howell, 1993).

Child abuse and maltreatment are also serious problems in the United States. In 2012, almost 686,000 children were found to have been victims of abuse or neglect, which is about one in 100 children (HHS, 2012). In addition, there are likely many more cases that go unreported or unresolved. The effects of child maltreatment are great, with the most recent total estimated annual cost of child abuse and neglect at $124 billion in the United States (Fang, Brown, Florence, & Mercy, 2012). Maltreatment is associated with a number of adverse lifetime consequences for children, including poor physical, emotional, and mental health, social difficulties, cognitive dysfunction, high-risk health behaviors, and behavioral problems (Child Welfare Information Gateway, 2013).

There is a relationship between child behavior and child maltreatment, with an increasing recognition of the bi-directionality of this relationship (Lytton, 1990). Children with behavioral disorders were found to be the largest subtype of children with disabilities, who as a group were two-to three-and-a-half times as likely to be maltreated when compared with a control group in a large hospital- and school-based epidemiological study (Sullivan, 2003). Though it is typically assumed that child maltreatment results in child behavior issues, there is evidence that disruptive child behavior can lead to increased child maltreatment. In a study of parenting behavior toward children with disruptive behavior and children without disruptive behavior, the greatest number

of negative parenting behaviors were displayed toward children with disruptive behaviors, irrespective of whether or not a child had received a diagnosis for behavioral disorder (Anderson, Lytton, & Romney, 1986). In addition, parents of children with a diagnosed behavior disorder displayed the most negative parenting behaviors. This suggests that a history of child disruptive behavior, particularly at a level to warrant a diagnosis of disruptive behavioral disorder, tends to elicit negative parenting behaviors. The relationship between child maltreatment and disruptive child behavior will be discussed further below in a review of the "coercion hypothesis."

It is important to consider the ramifications of psychosocial issues in children. While it is often difficult to attribute problems later in life to earlier events due to the complex interaction of the event and the impact on the child and his or her systems, in a review of literature on the topic, Kendall-Taylor and Mikulak (2009) dismissed the notion that childhood disorders are predominantly transient phenomena that children will outgrow. Instead, these researchers suggested the mechanisms through which early disorders may affect a child throughout life. According to Kendall-Taylor and Mikulak, early emotional and behavioral issues may put a child on a path to develop subsequent mental health disorders due to changes in the child's development as a result of these early problems. Changes that may impact further development include impairments in the child's ability to build healthy relationships with peers and adults or deficiencies in the child's cognitive or regulatory abilities (Kendall-Taylor & Mikulak, 2009). The specific course from early developmental disruptions to later problematic functioning will be explored later in this dissertation, but the point here is that early emotional and behavioral problems impact a child across time, and impact the multiple systems in which a child functions.

PCIT as a Treatment

Parent-child interaction therapy (PCIT) has been found to decrease behavioral problems, increase parenting skills, and decrease child abuse potential, in addition to positively impacting a number of other psychosocial issues in children between the ages of 2 and 12 (Hood & Eyberg, 2003; Timmer, Urquiza, Zebell, & McGrath, 2005; Urquiza & McNeil, 1996). PCIT has been deemed an effective evidence-based treatment (EBT) for helping reduce childhood disruptive behavior disorders and the occurrence of child maltreatment by several U.S. government organizations and clearinghouses (Child Physical and Sexual Abuse Guidelines, 2004; United States Public Health Service, 2001; The Pediatric Clinics of North America, 2009; The California Evidence-Based Clearinghouse, 2006; The National Child Traumatic Stress Network, 2005). An evidence-based treatment is one which is recognized by various sanctioning and governmental sources to be effective in treating a particular issue based on research and evidence. According to its developers, PCIT is a "short term, evidence-based intervention designed for families with children… experiencing a broad range of behavioral, emotional, and family problems" (Herschell, Calzada, Eyberg, & McNeil, 2002, p. 9).

Parents in PCIT learn techniques for working with their children and building relationships. PCIT consists of a child-directed intervention phase (CDI), in which parents learn appropriate ways to play with their children and communicate. This is followed by a parent-directed intervention phase (PDI), which teaches parents specific behavioral management techniques to help "parent" their children. PCIT has been found to be effective in reducing child behavior problems (Eyberg & Robinson, 1982; for a review, see Thomas & Zimmer-Gembeck, 2007), improving parenting skills (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993;

Eyberg & Robinson, 2008; Hood & Eyberg, 2003), and reducing parent stress (Hood & Eyberg, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998;). PCIT is currently being adapted for use in a variety of settings beyond the traditional clinic context for which it was manualized (for a review, see Eyberg, 2005).

Wilderness Therapy Camps as a Treatment

Another way to address these problematic child issues are with wilderness therapy camps. Wilderness therapy camps are intended to increase the biopsychosocial wellness of youth in an outdoor setting. There are a variety of these camps differing by population served, programming provided, and level of intensity, among a number of other factors. In terms of populations served, the most common psychiatric disorders of youth who participate are behavioral issues, learning difficulties, familial conflict, conduct disorders, and mood disorders (Davis-Berman, Berman, & Capone, 1994).

There is a general lack of agreed-upon terms to describe these types of camps, with labels such as "therapeutic camp," "recreational therapy camp," and others used interchangeably by different sources (Russell, 2001). In an effort to bring agreement among practitioners in the field, various sources have called for the term "wilderness therapy" to be used to refer to the various types of camps. These camps are characterized by having therapeutic agendas, occurring in natural locations, and are for youth with special needs (for a review, see Russell, 2001). Characteristics of wilderness therapy include the following: therapy takes place within a group context, there are a series of challenges youth will encounter in programming, and the programs are usually in the wilderness. In addition, therapeutic techniques, such as journal writing or

reflection are used, and there are many variations in camps based on the needs of the youth and resources available (Kimball & Bacon, 1993). Examples of outdoor programs which may be considered a type of wilderness therapy are adventure-based therapy, challenge courses, and ropes courses. Wilderness therapy is generally based in one of two settings, either centered at a base camp, or expeditioning to different locales (Crisp, 1998). Goals of wilderness therapy programs may include not only therapy, but also personal growth, education, or rehabilitation.

Wilderness therapy programs are distinct from "boot camps," a type of program normally employed for juvenile offenders; these camps make use of aggressive tactics, and are normally designed to instill discipline through intimidation. The distinction between wilderness therapy and boot camps is important to make because this is the image many people in the public have about wilderness therapy, which is not accurate. Furthermore, boot camps have not been shown to yield significant improvements in targeted child behaviors, and boot camp practices can often be considered cruel or unusual (for a review, see Russell, 2001).

Wilderness therapy camps are designed to therapeutically benefit participants through a variety of methods, one of which is incorporating conventional approaches to mental health treatment, such as therapy sessions and behavioral reinforcement, into the camp setting. Another approach implements therapeutic camp programming. These programs are designed to elicit therapeutic gains in campers through their completion of certain challenging tasks in a group context, such as completing a ropes course using teamwork. Finally, some therapeutic camps are intended to provide campers with a traditional camp experience using therapeutic behavioral management, without which campers would likely not be able to participate. Each of these

approaches may be utilized exclusively within a particular camp or in conjunction with the other techniques.

These methodologies will be described more in depth in following sections. As will also be discussed in subsequent sections, the research literature concerning the efficacy of wilderness therapy camps has been limited. However, there have been studies which substantiate that these camps can be helpful for children with psychosocial issues, as well as for general improvements in child functioning (Hattie, 1997; Neill, 2003; Wilson & Lipsey, 2000).

Importance of effectively training camp counselors. In a statement to the United States House of Representatives, researchers from the General Accountability Office recounted a number of drastic cases in which a child died while in the care of a wilderness therapy camp (Committee of Education & Labor, 2007). The researchers reviewed records of reported incidents of abuse in residential wilderness therapy camps, predominantly those in remote locations and for adjudicated youth, as well as details of court cases of some of these incidents. They concluded that a contributing factor in the occurrence of these cases was lack of appropriate training of camp staff, specifically lack of training in counselors' management of camper behavior issues and how to properly monitor camper health, specifically ensuring campers received adequate nutrition (Committee of Education & Labor, 2007). In addition, the researchers pointed out that there are currently no federal laws that regulate residential treatment programs, of which wilderness camps are considered to be a part (Committee of Education & Labor, 2007).

One method camps have used to train staff in necessary skills is cross-training. Through this approach, staff members are trained in all skills necessary, such as safety procedures, conducting activities, and psychotherapy. This approach to training helps ensure that any staff member is able to meet the needs of the youth, which may be beneficial if a particular staff member is unavailable. However, through interviews with a number of camp administrators, Crisp (1998) learned that this is often not done; rather, staff with complementary skills are paired together, such as having a staff member trained in behavior management paired with a staff member trained in psychotherapy. These choices are made for reasons of expediency, as well as for financial and practical considerations. Many program administrators also find fault with existing training programs for clinicians (Crisp, 1998). This may be problematic because staff will lack a true understanding of all factors necessary in providing a superior therapeutic experience for campers. Therefore, if some staff members are unavailable, then certain skills necessary may be unavailable. Furthermore, communication between staff members to coordinate necessary skills may be problematic.

There have been calls from leaders in the therapeutic camping field to improve training procedures and require them to be informed by evidence-based training methods (Crisp, 1998; Davis-Berman & Berman, 1994). In a review of the literature regarding program implementation and training, Gillis and Gass (2003) reported that there is no consensus as to how to train camp staff to conduct therapy and programs in wilderness therapy. The uncertainty about which approaches to employ in training staff is complicated by the number of different programs and approaches available for working with youth. The result is that therapeutic wilderness counselors and administrators are left with little guidance regarding how to employ

evidence-based treatment approaches with campers. In a review of the research outlining necessary components of treatment at therapeutic camps, Crisp (1998) stated that the following factors are necessary components of treatment at therapeutic camps. Treatments should: affect systems, provide assessments and a plan, allow for flexibility, integrate various aspects of treatment, monitor client outcomes, be based on theoretical paradigms, provide staff skills through training, and have been vetted as efficacious based on research.

Utilizing Early Interventions

Given the impact that early childhood events may have on subsequent development and on society at large, it stands to reason that early intervention which addresses disruptions in child development and aims to prevent these disruptions would be sound policy toward ensuring optimal child and social health. In defining an approach toward this goal of health, the Institute of Medicine (1994) endorsed not only prevention of child disorders, but also treatment and maintenance. Later research institutes reiterated many of these early recommendations from the Institute of Medicine (Center on the Developing Child, Harvard University, 2008; National Scientific Council on the Developing Child, 2007). The Institute of Medicine defined the essential steps of treatment as consisting of proper identification and standard treatment to address both the disorder and the likelihood of future co-occurring disorders. In terms of maintenance, the Institute of Medicine recommended that clinicians make efforts to enhance the patient's adherence to long-term treatment to address current issues and prevent future relapse, and also to provide long-term follow up services to ensure continued patient health.

The Institute of Medicine made several recommendations to address child mental health issues. One recommendation is for mental health practitioners to adapt a preventative approach, in which risk and preventative factors which are associated with a disorder are identified and early intervention is provided to prevent the occurrence and worsening of the disorder (Institute of Medicine, 1994). In a recent statement, the director of the National Institute of Health (NIH), of which the National Institute of Mental Health (NIMH) is a member institute, outlined the NIH's intended preventative approach toward treating disease as being preemptive, predictive, and personalized (Klose, 2008). In other words, it is important to be preemptive in treating those who may develop issues, be predictive in anticipating who will develop these issues, and be personalized in adapting treatment to individuals. This approach promises to be more efficacious than reactive treatment, in that treatment will be provided early in the course of a disorder's onset, when the potential to impact the disorder is greater, before it becomes more entrenched.

The challenge with this approach is identifying the characteristics associated with the development of disorders and identifying people that have these characteristics among a population. Wilderness therapy camps may often include children who have sub-threshold disordered behavior or who may be at risk for developing disorders. While these children may not be identified as having a problem in the way that children with a physical problem would be identified through physical screenings, these children may be identified through recognition of risk factors and early behavioral issues by adults in their lives. These children may not receive traditional services, such as individual therapy, but may benefit from attending a therapeutic camp, which may help prevent the occurrence of disorders. The mechanisms through which

wilderness therapy camps can benefit this group of children will be discussed in following sections.

Utilizing Evidence-Based Treatments

The second recommendation of the Institute of Medicine, to provide standard treatment, is becoming more pronounced in psychology through the identification and use of evidence-based practices. Though there is no universally agreed-upon definition of evidence-based practice, as exemplified by the multiplicity of definitions used by different sources endorsing evidence-based therapies (Child Physical & Sexual Abuse Guidelines, 2004; Evidence-Based Treatment for Children & Adolescents, Youth Violence: A Report of the Surgeon General, 2001; Shipman & Taussig, 2009; The California Evidence-Based Clearinghouse, 2006; The National Child Traumatic Stress Network, 2005), researchers and the mental health community have begun to agree on several criteria which are considered when evaluating the efficacy of a particular treatment. These criteria, as outlined by Kazdin and Weisz (2010), are that a treatment should be evaluated in at least two published studies, in which the components of a randomized controlled trial (RCT) are implemented. These components consist of a carefully specified population, random assignment of participants into different conditions, fidelity of treatments to treatment manuals, use of multiple outcome measures, statistically significant different outcomes between treatment and control groups, and replication of these results in different conditions. Use of treatments that have been through this vetting process for a particular disorder helps ensure that patients are receiving the most appropriate care.

While some efforts have been made to define and promote the use of evidence-based treatments (EBTs), the mental health service community has recognized the underutilization of these types of treatment, and has formed organizations to advocate for their dissemination and provide guidance for their implementation (for a review, see Herschell, Kolko, Baumann, & Davis, 2010). One of the difficulties noted in implementing EBTs was in training practitioners in their use. One approach toward the dissemination of EBTs for use among practitioners has been to develop training protocols for training staff in EBTs in various contexts.

Because clinicians in various settings have different characteristics, such as in the manner by which they treat clients, training programs may need to be modified based on the target setting. For example, one of the specific difficulties in the dissemination of EBTs that has been noted is training staff at less regulated community mental health settings, as compared with the relatively controlled conditions of university research clinics (Herschell, Kolko, Baumann, & Davis, 2010). As these researchers noted, in research clinics there tends to be great degree of oversight by researchers to ensure fidelity to manualized treatments by clinicians. In community mental health settings, there is typically less oversight, and fewer resources are devoted to ensuring fidelity (Herschell et al., 2010). Due to this comparative lack of oversight, strategies such as checklists and straightforward directions may need to be implemented to ensure compliance with treatment protocols. Modifications to existing EBT training procedures, such as disbursing checklists to clinicians, would help assist in the implementation of EBTs within their respective settings.

Researchers have acknowledged that as of yet, there are no definitive universal standards for best practices regarding methods for training practitioners in use of EBTs (for a review, see

Herschell, Kolko, Baumann, & Davis, 2010). A number of methods for training staff in EBTs exist, such as use of manuals, didactic training, role plays, and supervised training cases. Herschell et al. (2010) reviewed the existing literature concerning therapeutic training methods in studies from 1990 to 2009. In the first training method reviewed (use of manuals for training), the researchers found that utilizing training manuals may be necessary, but is not sufficient in itself, for trainees to gain mastery. Trainees typically gain knowledge through reading materials, but these gains tend to be short-lived and less thorough than gains from other methods (Herschell et al., 2010). The next training method reviewed was self-management training, in which trainees reviewed a videotape or online source. This method tended to yield favorable reviews from trainees, was cost effective, and increased knowledge. However, the efficacy of this modality was dependent on trainee characteristics, such as the trainee's ability to generalize these methods to real-life application (Herschell et al., 2010).

A third training method reviewed by Herschell, Calzada, Eyberg, and McNeil (2010), workshops, such as those utilized when providing continuing education of professionals, was found to yield some increases in participant knowledge; however, on the whole, workshops impacted participant behavior, attitude, or application of skills very little (Herschell et al., 2010). In one instance, there was increased use of targeted skills, but these behaviors disappeared shortly after the workshop. In terms of the length of workshops, 1- to 3-hour workshops were found to yield no change in skills or knowledge. Workshops longer than this were found to yield benefits, but the length of the workshop did not correlate with increased benefits, suggesting that, at a point, participants stop learning, possibly due to saturation (Herschell et al., 2010).

Workshop supplements, such as feedback and observation, were found to be effective in training trainees in new therapeutic skills. Conducting role-plays and providing feedback in a variety of situations that the trainee is likely to encounter were especially helpful techniques for assisting trainees in gaining skills and retaining them (Herschell et al., 2010). Train-the-trainer methods were relatively little researched, and methodologies employed in these studies were not rigorous. However, there was some suggestion that these methods are promising. The most promising method seemed to be combining the above methods (including manuals, self-instruction, workshops, role-plays with feedback, and train-the-trainer methods) into one multi-method training. Using this multi-method approach, 19 out of 21 studies reported significant improvements in trainee aptitude upon completion of the training; however, due to differences in training program components among studies, it is difficult to make comparisons.

To summarize, utilizing EBTs has been recognized as being of primary importance in delivering superior treatment to those in need (Saunders, Berliner, & Hanson, 2004; HHS, 2001b; Shipman & Taussig, 2009; The California Evidence-Based Clearinghouse, 2006; The National Child Traumatic Stress Network, 2005). One of the challenges in using evidence-based therapies is in appropriately training practitioners in their use and assessing their efficacy. Research has been and will continue to be conducted to ascertain the best means to train practitioners in EBTs.

Engaging and Sustaining Youth in Treatment

The process of engaging clients to participate in therapy and continue to participate can be viewed as containing several steps, as well as choices the client and his or her family make about whether or not to participate. Eysenbach (2005) applied the process formulated by Rogers

(2003) regarding the general adaptation and use of innovations, to the utilization of mental health services within a community. This process first consists of a diffusion of the service to prospective clients, normally through change agents, or those people in contact with the service and the community. In terms of a community member initiating a certain type of therapeutic treatment or deciding to begin therapy at all, this decision may be influenced by key community figures or contact persons recommending mental health services and certain therapies.

Once services have been initiated, the decision to remain in therapy or not can be influenced by the manner by which the participant perceives the following characteristics, according to Eysenbach (2005): the relative advantage to remaining in a particular therapy versus not remaining, the compatibility of the therapy with existing values, the degree of complexity of the therapy, and how observable the impact of the therapy is to others. The challenge in promoting mental health services usage among potential clients is to get the clients engaged in the therapeutic process and for them to realize the advantages of participating. This analysis of the decision process of whether or not to engage in treatment suggests that utilizing treatments or therapeutic activities which are viewed favorably in a community may increase the initial and continued use of these services. This suggests that creating programs which are consonant with community values may result in the recommendation of these programs throughout a community by figures who have become aware of these programs.

Once engaged in these programs, the degree to which the programs seem to offer benefits and are concordant with existing values, in other words treatments which seem to offer something to the participant and seem familiar, are likely to result in continued use of the program. An example of creating a treatment consonant with community values is incorporating

treatment within other programs in which a community would typically engage, such as including therapeutic treatment within a summer camp. The importance of creating treatments that reflect community values is related to the following consideration in the development of effective treatments, that of reducing stigma.

Reducing stigma associated with mental health services. In terms of barriers impeding potential recipients of mental health services from obtaining these services, Norris and Alegria (2005) identified that discomfort with seeking help, perceived stigma, and mistrust were some of the most significant factors that impeded individuals from seeking services. Citing a study by Kaniasty and Norris (2000), Norris and Alegria (2005) described that in a survey administered after a recent hurricane in the United States, respondents reported feeling most comfortable seeking help from family, somewhat less comfortable seeking help from friends, and least comfortable seeking help from outside sources. In a report by the Surgeon General (HHS, 2001a) stigma was identified as a critical barrier keeping individuals from obtaining mental health services. To many, it can feel shameful and embarrassing to feel disordered or in need of help. Finally, many people feel mistrust toward mental health providers, especially if they feel that the clinician would be harsh or judgmental toward them (Norris & Alegria, 2005). This view is especially pronounced among racial minority individuals in the United States. In a comprehensive report, the Office of the Surgeon General of the United States addressed the distrust that racial minorities often feel toward the mental health system (HHS, 2001a). Among factors contributing to this distrust include a history of broad mistreatment of minorities by the majority society and government, a history of unethical practices toward minorities in research

and treatment, a lack of access to treatment, and a lack of culturally sensitive treatments (HHS, 2001a).

One approach to increasing trust and utilization of mental health services outlined in the Surgeon General's report was to reduce stigma associated with those services, which can prevent people from seeking services due to shame (HHS, 2001a). An effective approach to reducing stigma is to offer these services in naturalistic settings and integrate mental health services into other programs (Norris & Alegria, 2005). Camps may offer the possibility of providing mental health treatment while providing recreation and activities. By so doing, the stigma of obtaining the mental health treatment is reduced because the treatment is embedded in activities that typically wouldn't be seem to be mental health services. For example, social skills that are learned through group therapeutic camp activities at a camp for children with social anxiety are not an overt form of therapy. However, the therapeutic benefits are real.

In addition, there have been descriptions of efforts to reduce stigma by adapting evidence-based treatments for particular populations and making them seem less therapeutic. An example of this approach is that researchers adapted PCIT to be more compatible with Mexican-American families by changing the language used in the treatment to be less stigmatizing (McCabe, Yeh, Garland, Lau, & Chavez, 2005). Further discussion of adaptations of treatments to meet specific group needs is provided in the current study's literature review.

Problem Statement

In summary, there are a number of psychosocial issues that negatively impact long-term youth development that are currently prevalent (HHS, 1999). The negative impact of these

issues on youth and society is far-reaching (National Research Council, 2009), and interventions to address these issues should be implemented. However, existing interventions have been problematic for many of the reasons discussed above, including: (a) having inconsistent training procedures; (b) not intervening early in the course of disordered development; (c) not using standardized treatment procedures, and (d) not engaging and sustaining youth in treatment through reductions in stigma associated with treatment and incorporating community values in treatment.

To better address these issues, health professionals have begun to advocate and adopt approaches to treatment with a greater emphasis on early intervention than was previously used (Institute of Medicine, 1994). Also, there have been increased calls for utilization of evidence-based treatments, treatments which have been found to be efficacious in controlled research studies (for a review, see Herschell et al., 2010). Finally, treatments which reduce stigma and are consonant with community values tend to be utilized at a greater rate and for longer periods of time than more conventional treatments (Eysenbach, 2005; Norris & Alegria, 2005).

Wilderness therapy camps have been found to be effective for treating a number of youth issues and for generally improving youth functioning (Hattie, 1997; Neill, 2003; Wilson & Lipsey, 2000). In addition, wilderness therapy camps appear to address current treatment needs of reducing stigma in treatment and providing other benefits, such as physical and social health advantages. However, current wilderness therapy camps lack systematic training for staff that has been deemed efficacious. To date, no formal model of training has been developed and implemented. Moreover, there is a need for a training program utilizing evidence-based techniques. As indicated, there have been findings suggesting that current training programs

used at camps have been inadequate in teaching staff proper techniques for working with youth with special needs (for a review, see Gillis & Gass, 2003). A number of wilderness therapy camp leaders have recognized this need and have begun expressing the importance for standardized training methods to be adapted in training wilderness therapy camp staff (Crisp, 1998; Davis-Berman & Berman, 1994).

PCIT has been found to be an effective evidence-based therapy for use with children with a variety of issues and backgrounds and in diverse settings, and has proven useful for reducing child problematic behaviors (Eyberg & Robinson, 1982; Thomas & Zimmer-Gembeck, 2007), as well as improving parenting skills and reducing parent stress levels (Eyberg & Robinson, 2008; Hood & Eyberg, 2003; Timmer, 2005). Efforts have been made to expand the use of PCIT in a variety of settings, with promising results (Eyberg, 2005), which will be further discussed in the current study's literature review (see Chapter 2). To date, PCIT has not been used in the wilderness therapy camp setting to train staff. Based on PCIT's adaptability and efficacy in settings with similar characteristics as wilderness camps (Gershenson, Lyon, & Budd, 2010; Diamond, 2010), it appears promising that PCIT would be adaptable for use in training wilderness therapy camp staff and could lead to efficacious results. A program adapting PCIT for use in wilderness therapy camps would be beneficial for the staff working at those camps, the children attending these camps, and for the field to document the adaptation of an EBT in a naturalistic setting. This dissertation proposes to describe how PCIT might be adapted to train wilderness therapy camp staff in evidence-based methods for working with youth, especially those with mental health needs, such as behavioral issues.

Outline of Remaining Chapters

In this chapter, a number of the psychosocial issues that children encounter were mentioned. Two treatments for many of these issues, PCIT and wilderness therapy camps, were introduced and described. Issues to address regarding these types of treatment include: (a) wilderness therapy camp staff need a standardized efficacious training program, (b) PCIT and other evidence-based treatments need to be implemented in community settings to reach and retain the greatest number of users, (c) EBTs should be used in preventative capacities, and (d) stigma associated with obtaining mental health treatment should be reduced via alternative treatments.

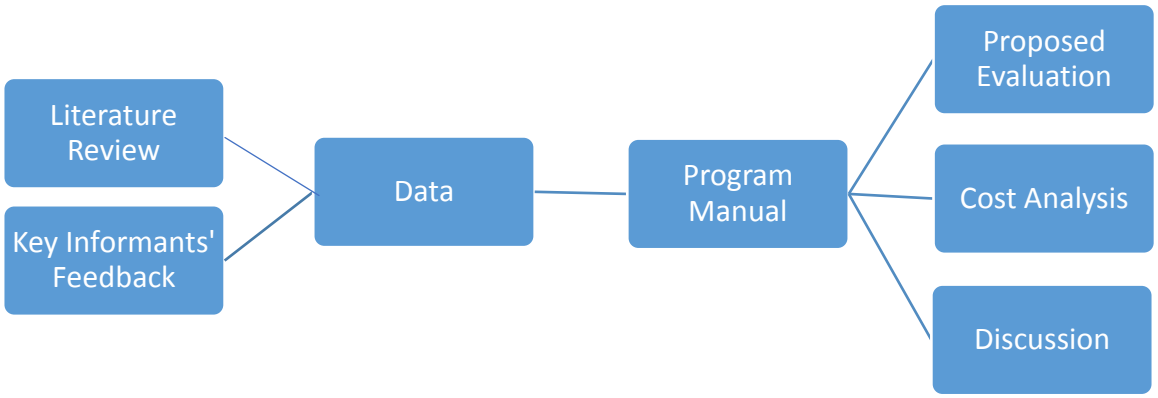
In Chapter 2, the literature concerning PCIT and wilderness therapy camps will be reviewed. In reviewing the literature on PCIT, its efficacy and applicability to a variety of situations and with a variety of populations will be emphasized, as well as recent research in which PCIT is being disseminated in community treatment settings that may be similar to camp settings. The wilderness therapy camp literature will be reviewed in terms of its efficacy and current training methods.

In Chapter 3, methods of needs assessment will be described. Key informants, experts in the fields of wilderness therapy, PCIT, and training methods, will be interviewed to obtain their insight about the needs for interventions for children with behavioral issues, staff training needs, and how these needs are currently being met. A proposal for a model for adapting PCIT as a training program for camp staff will be presented to these key informants, and their feedback and suggestions for the program will be presented. Based on feedback obtained from these interviews, a full program for training camp staff will be proposed.

Finally, a proposal to evaluate the efficacy of this program will be put forth. This evaluation would allow a researcher to evaluate the efficacy of the program if it were implemented. As part of the proposed evaluation, a financial assessment will be conducted on the program, and the results will be presented.

This process is illustrated in the following figure:

Figure 1: *Dissertation Process Diagram*



Chapter 2: Literature Review

Review of Historical and Theoretical Background

PCIT theoretical and historical background. PCIT is based in attachment theory, social learning theory, and behavioral techniques (Brinkmeyer & Eyberg, 2006). Attachment theory is based on the work begun by Bowlby (1969), then later Baumrind (1967), which posits that there is a relationship between the early behavioral patterns of parents and children, their interactions, and later child development. Baumrind initially classified three patterns of child behaviors, with one type considered as being a secure attachment, and characterized by children being secure, self-reliant, and explorative. She considered the other two types of attachment to be insecure, with children as being withdrawn and distrustful or having little self-control and retreating.

Baumrind then postulated that certain types of parenting styles lead to children developing one of these patterns (1967). After observing children interacting with their parents on various tasks, Baumrind coded her results and found that parents of securely attached children were consistent with their children, demonstrated control of their children, were supportive, and communicated clearly. These parents also respected their child's independence, but held the child to a position once decided (Baumrind, 1967). This type of parenting became to be later termed authoritative parenting.

Parents of the insecurely attached children were characterized by being either highly controlling of the children, providing little nurturance, not using reasoning with the children, and/or not encouraging the children to communicate (Baumrind, 1967). This style of parenting became to be known later as authoritarian parenting. Other parents of insecurely attached children were not controlling of the children, were less organized, were more insecure about parenting, communicated less with children, had fewer expectations, and tended to use withdrawal of love as a consequence for child behavior (Baumrind, 1967). This parenting style was later termed permissive parenting.

Because children who exhibited securely attached behavior tend to be viewed as having the healthiest developmental behaviors, efforts have been made to foster this style in children. Because of Baumrind's work, it became clear that a certain parenting style, namely authoritative parenting, tended to be associated with this child behavioral style. Thus, when developing PCIT, early formulators made efforts to develop strategies to teach the skills inherent in authoritative parenting to parents. The techniques that PCIT therapists encourage in parents are to praise, reflect children's statements, imitate children's play, describe what children are doing, and show enthusiasm. The skills that the therapists discourage are to question the children, command them, or criticize them. All of these skills aim to enhance authoritative parenting skills.

PCIT is also based in social learning theory. Social learning theory was developed by Bandura (Bandura, Ross, & Ross, 1961) and provides an explanation for how people come to learn things. Rather than learning through direct instruction, much of the way people come to learn is through observation and imitation of others. In a series of experiments, children were exposed to various stimuli and their subsequent behaviors were observed for changes (Bandura

et al., 1961). These researchers found that children who observe others behaving in certain ways are likely to be influenced by this behavior and imitate it. Thus, social learning theory might explain the process by which children may come to be influenced by their parents' behavior, and in turn, come to exhibit similar behavior. Children are not often directly instructed to behave in a certain way by their parents, but they observe their parents and come to behave that way also (Bandura et al., 1961). This reinforces the importance of helping parents to develop parenting behaviors which have been identified as leading to the most desirable child behaviors. This also informs therapist behavior during PCIT sessions, in which the therapist should model the PCIT skills to help parents learn them.

Another theoretical basis for PCIT techniques is behaviorism. Behavioral techniques are used in PCIT in the way that therapists work with parents. Therapists praise parents when they use the PCIT skills, encourage them to use skills when they do not use them, encourage repeated practice of the skills both in session and at home until the skills are overlearned, and use rewards with children who successfully participate in PCIT. PCIT techniques that are taught to parents to be used with children also similarly incorporate behavioral principles. Parents provide positive reinforcement in the form of praise and attention when children are behaving appropriately, and use selective ignoring to extinguish off-task behavior which can be tolerated. Parents are also taught discipline techniques that involve punishment without giving attention.

Related to behaviorism, the coercion hypothesis, developed by Patterson (1982), illustrates the effect contingencies have on child and parent interactions and behavior patterns. According to this model, during parent-child interactions, children can be reinforced when they respond to parent requests in negative ways when such negative responses lead to a cessation of

the parent request. For example, parents may ask their child to complete a task, such as put away a toy. If the child does not cooperate the parent may become frustrated and repeat the request, threaten punishment, or communicate exasperation. The child may become increasingly defiant toward this request, which has often in the past lead to aggression or other difficult behaviors. At this point, the parent may view this ensuing struggle as being more difficult than it is worth and redact the request, instead putting away the toy herself. The child has learned that this defiant behavior is effective in coercing his parents to not place demands upon him and will continue to use this strategy. Researchers have observed this pattern of interaction in an observational study (Eddy, Leve, & Fagot, 2001).

Therefore, one of the goals of PCIT is to eliminate this pattern of defiance, which leaves the parent frustrated and having to complete the child's tasks, and leaves the child learning the lesson that if he is defiant enough and makes enough of a problem, he can do what he wants, a lesson that may lead to more drastic consequences in society. PCIT therapists attempt to address this pattern by asking parents to state their requests in clear terms and then upon non-compliance, presenting the child with a choice between acceding to the request or receiving a negative consequence. Parents are instructed to remove the emotional content from their statements so that they do not become frustrated or lose control and do not establish a condition in which communication escalates in volume and negativity. In addition, parents are instructed to follow through with consequences consistently, even if the child eventually complies with the task, as consistency is important.

In summary of the literature upon which PCIT is based, parents and children are encouraged to develop their relationship through parents attending to their children and

following their play. Social learning theory involves the way in which both parents and children learn to interact in PCIT. Therapists model appropriate parenting behaviors, which parents imitate and then come to learn to do naturally, and parents model appropriate play behavior, which children come to imitate and learn to also do naturally. One of the developers of PCIT explained the efficacy of PCIT from the framework of the "coercion hypothesis," which proposes that parents who only respond to negative child behavior are actually reinforcing the child to act in negative ways. Through PCIT parents learn to ignore negative child behavior and reinforce positive behavior. In addition, parents learn effective disciplinary techniques to manage their children's disruptive behavior.

The primary formulator of PCIT, Sheila Eyberg, based PCIT on the above models, developing behavioral techniques which utilized the above theory to help parents and children interact more healthily (Eyberg, 1988). She also developed a system for coding parents' use of these skills in an assessment called the Dyadic Parent-Child Interaction Coding System (DPICS). PCIT consists of two phases, child-directed intervention (CDI) and parent-directed intervention (PDI). In the initial phase, CDI, parents are taught the skills for engaging their children in play. These skills consist of target behaviors that parents should exhibit (for example, praising the child), and behaviors parents should avoid (for example, questioning the child). The goals of this phase are to build the relationship between the parent and child, foster the child's interest in leading play with the parent, and help the parent develop skills for when they will give directions to the child. Upon successful parental attainment of these skills, which is determined by demonstrating them sufficiently (as assessed with the DPICS), participants begin the next phase, PDI. The goal of PDI is for parents to learn to give directions to their children and to foster their

children's compliance through use of appropriate disciplinary techniques, such as a time-out procedure.

When parents have successfully demonstrated these techniques, they have completed PCIT. Therapists help the parents to learn these skills through coaching via an earpiece while the parents are engaged in play with the children. Instruction of the parents takes place in the first session of each of these phases in a didactic format, with role plays. Eyberg also described that the coaching can be done in person or through the use of the earpiece. Eyberg and others began researching this treatment with oppositional children, children with attention difficulties, and children with developmental delays.

In one of the first studies examining PCIT, Eyberg and Robinson (1982) conducted PCIT with seven families whose children were between the ages of 2 and 7. Participants consisted of families that had a child who was displaying active behavior problems at home and a sibling between the ages of 2 and 10. Parents and children were given pre- and post-treatment assessments, which measured a number of parent and child behaviors and emotional factors through self-report and observation. Significant changes that were found to occur from pre- to post-treatment included declines in several maternal MMPI scale scores and Taylor Manifest Anxiety scores (Eyberg & Robinson, 1982). Parents also reported observing substantially less intense negative behaviors at home. Parents were observed by researchers to give fewer commands, ask fewer questions, give more praise, and describe their children's actions more from pre- to post-test (Eyberg & Robinson, 1982). These are the targeted parental behaviors in PCIT.

Children in Eyberg and Robinson's study were observed to demonstrate a decline in deviant behavior and have a lower ratio of non-compliance to commands (1982). These effects were found to generalize to the sibling who was not actively involved in PCIT (Eyberg & Robinson, 1982). Parents also recorded very high scores on the Therapy Attitude Inventory (TAI; mean 46.8 out of 50), a measure of parent satisfaction with the treatment (Eyberg & Robinson, 1982).

Timmer, Urquiza, Zebell, and McGrath (2005) described a case study involving a young boy who was having behavioral problems in foster care placement. This boy had been put into the child welfare system at ten months, after his brother was born testing positive for a variety of drugs at birth. The boy went through six different foster care placements and exhibited very aggressive behavior at each placement, including head-banging, biting, and hitting. At 2 years, 7 months of age, the boy and his mother entered treatment, as the mother was attempting to regain custody. However, the mother discontinued planned reunification, which resulted in another foster placement (Timmer, Urquiza, Zebell, & McGrath, 2005).

Seeking assistance with the boy's difficult behavior, the new foster mother entered PCIT treatment (Timmer et al., 2005). Before beginning treatment, the foster mother rated her son on the Eyberg Child Behavior Inventory (ECBI), an assessment that is commonly used in PCIT to gauge the level of externalizing behaviors in a child. The child was reported to have clinical levels of intensity and a number of behavior problems (Timmer et al., 2005). At mid-treatment and post-treatment points, the inventory was again administered. The child showed a significant drop in acting-out behaviors and in the post-treatment condition, fell below clinical levels of behavior problems (Timmer et al., 2005). The foster mother's stress was assessed with a

questionnaire titled the Parent Stress Index (PSI). This showed that the mother's stress resulting from viewing the child's behavior as problematic dropped from clinical or borderline levels at pre-treatment to within normal ranges by post-treatment (Timmer et al., 2005).

Could the lowered parent stress levels experienced by this foster mother be a result of fewer problems from the child, greater parental feelings of control, or both? Perhaps both factors interacted to produce less stress in this parent. The single case study format of the article illustrates how PCIT can be adapted for families based on their need, as the parent-directed intervention required extra time due to the child's excessive use of negative behaviors.

PCIT has been shown to be an effective treatment for improving child behavior across several studies, as reviewed by Thomas and Zimmer-Gembeck (2007) in a meta-analysis conducted on 13 studies from 1991 to 2003 examining the effects of PCIT on children between the ages of 3 and 12 in the U.S. and Australia. All randomized control trials and long-term follow-up studies using PCIT which were published during that time period were identified in those two countries. Outcome variables were gathered from reports and observations of parent and child behaviors. Effect sizes were calculated for each outcome by subtracting the pre-treatment scores from the post-treatment scores and dividing by the standard deviation of the pre-treatment scores (Thomas & Zimmer-Gembeck, 2007). Results indicated medium to large effect sizes in improvements in both negative and positive child behavior from pre- to post-treatment, as measured in clinic observations (d= -.54 and .94, respectively). In addition, large effect sizes were found in both mother and father reported reductions in child negative behaviors (d= -1.31and -.83 respectively). Also, there were positive changes in parenting behaviors, as indicated in both parenting reports and clinical observations (d= 1.11-3.11; Thomas & Zimmer-

Gembeck, 2007). Taken together, the results of this meta-analysis suggest that across a number of studies, PCIT has had a positive impact on child and parent behaviors.

Results from another study, which compared families who completed PCIT with families who did not fully complete PCIT treatment, suggest that PCIT efficacy will sustain over time as well (Boggs et al., 2004). Forty-six families agreed to participate in a follow up study from a pool of 61 initial families (75%) who began PCIT due to child behavior problems at least 10 months and up to 3 years earlier. Among these 46 families, 23 completed PCIT in an average of 13.8 sessions. The 23 families who dropped out averaged 3.6 sessions. Demographic factors were not significantly different between completers and drop-outs (Boggs et al., 2004).

All families in the study completed inventories at pre-treatment and follow-up time points 1 to 3 years after treatment, including the Eyberg Child Behavior Inventory (ECBI) Parent and Child Scales, The Parenting Stress Index (PSI) Parent and Child Scales, and the Parent Locus of Control Scale (PLOC), which is designed to measure the amount of control a parent feels over his child's behavior (Boggs et al., 2004). Analyses of measures from pre-treatment to follow-up found that for the completer group, there were significant decreases between pre-treatment and follow-up in the mothers' ratings of their child's disruptive behavior frequency (ECBI Intensity Scale) and their parenting stress levels (PSI Parent Domain and PSI Child Domain), and significant increases in the parents' tolerance for their children's misbehavior (Boggs et al., 2004). None of the comparisons for the families who dropped out were significant. This study suggests that remaining in PCIT yields better outcomes than dropping out of treatment; however, there may have been differences between families that remained in treatment and those who dropped out, which may better account for the different outcomes.

The effects of PCIT were found to be even longer lasting in another study (Hood & Eyberg, 2003). Researchers were able to obtain follow up information from 23 families who had participated in PCIT 3 to 6 years earlier. These families were given the ECBI, PLOC, and Beck Depression Inventory-II (BDI), a self-report measure of adult depressive symptoms at pre-treatment, post-treatment, and follow up times (Hood & Eyberg, 2003). In examining effect sizes from pre-treatment to post-treatment, it was found that there were large effect sizes for the PLOC and ECBI and medium effect sizes for the BDI. From post-treatment to follow-up, the effect sizes were close to zero for the BDI, PLOC, and ECBI Intensity Scale. The ECBI Problem scale yielded a medium effect size, with parents becoming somewhat more intolerant of child misbehavior after the conclusion of therapy (Hood & Eyberg, 2003). Taken together, results indicated there were fewer child behavior problems from pre-treatment to follow up, parents felt more able to tolerate their children's behavior, and mothers' locus of control was significantly more internal as well, which suggests increased perceived self-efficacy in her ability to manage her child's behavior (Hood & Eyberg, 2003). Not every participant participated in the follow-up evaluation, which may have influenced the findings. However, taken together, findings from this study and the preceding study suggest that the effects of PCIT are long-lasting.

PCIT and maltreatment. Treating behavior disorders may help reduce the incidence of child abuse. Children with behavioral disorders were found to be the largest subtype of children with disabilities, who as a group were two- to three-and-a-half times as likely to be maltreated when compared with children without disabilities in a large hospital- and school-based epidemiological study (Sullivan, 2003). Sullivan examined 39,000 hospital records and 50,000

school records and compared them against legal databases that recorded incidences of child maltreatment. Over 6,000 cases of maltreatment were found (Sullivan, 2003). These cases were examined for the type of abuse and type of disability of the child. In the hospital sample, 64% of maltreated children were found to have a disability, compared with 32% of non-maltreated children (Sullivan, 2003). The largest disability category in this group was behavioral disabilities, at 37.8%. In the school sample, 9% of children without a disability were maltreated, compared with 31% of children with a disability (Sullivan, 2003).

Sullivan found that the likelihood of receiving all types of abuse among children with disabilities was greatest for the children with behavioral difficulties (2003). Although this data was correlational in nature, it was postulated that when children exhibit behavioral issues, they are more likely to be abused by caretakers. Thus, by helping to control children's behavior and giving parents effective parenting skills, it stands to reason the level of maltreatment against this group will decrease.

Research has, in fact, supported this connection between improved child behavior and reductions in child maltreatment. In a review of the existing literature on PCIT, researchers (Herschell & McNeil, 2005) first described the rationale for using PCIT with families with instances of child physical abuse. They described findings of correlations between abuse and child behavior problems, children's young age, child inability to regulate emotion, low overall verbal interaction (but high negative verbal interaction), and inconsistent parental discipline. PCIT addresses each of these issues through the techniques that are taught to parents. The researchers then reviewed several studies which demonstrated the efficacy of PCIT in addressing child maltreatment in a variety of conditions (Herschell & McNeil, 2005).

In one study reviewed by Hershell and McNeil (2005), researchers examined PCIT's effectiveness in working with families whose children had experienced physical abuse (CPA; Chaffin et al., 2004). Researchers examined 110 physically abusive parent-child dyads over 4 years. As these dyads entered the child welfare system, they were randomly assigned to one of three treatment conditions: PCIT, PCIT with services such as substance abuse treatment or treatment for depression or marital problems, or a community-based parenting group. After 850 days, 19% of PCIT dyads had a re-abuse report, while 36% of PCIT plus services and 49% of the parenting group families did. These results indicated that PCIT alone was as effective or more effective in reducing subsequent instances of child abuse as PCIT with services, and more effective than another type of parent training (Herschell & McNeil, 2005). A possible explanation was that in the PCIT-only condition, parents were able to focus more directly on learning skills to prevent a re-occurrence of maltreatment than in other conditions.

In another study that examined the impact of PCIT on child abuse, researchers described a single case study in which a mother who had disciplined her child in an aggressive manner, but had not been found to have ever maltreated him, was referred for PCIT (Borrego, Urquiza, Rasmussen, & Zebell, 1999). The mother wanted to avoid using physically aggressive discipline with her child. This child, 3 years of age, was described by the mother as being physically aggressive with other children, not responding to her directions, and having numerous outbursts. Throughout PCIT the mother gave progressively less negative commands and stated fewer questions, and increased in the number of praises, descriptions, and reflections of her child's behaviors. During this time, the child was observed to have decreasingly less negative behaviors, which were maintained at 5-month and 16-month follow-up observations (Borrego et al., 1999).

Thus, this study illustrated the potential impact PCIT can have in reducing instances of first-time child maltreatment.

PCIT and stress. Increased levels of paternal stress are associated with having a child with oppositional defiant disorder (ODD) or another behavior disorder (Miranda, Marco, & Grau, 2007; Ross, Blanc, McNeil, Eyberg, & Hembree-Kigin, 1998). Ross, Blanc, McNeil, Eyberg, and Hembree-Kigin (1998) interviewed parents and children using a DSM-III structured interview and categorized the children into one of four groups: ODD-only (n=16), Attention Deficit Hyperactivity Disorder (ADHD) only (n= 27), ODD and ADHD dual diagnosis (n=39), or multiple diagnoses (ODD, ADHD, and conduct disorder [CD]; n=10). Parental stress level was assessed with the PSI. Results from the PSI indicated significantly elevated levels of stress for the Child-Directed Stress Index, a measure of stress associated with the child, and Total Stress Index, with percentiles all above the clinically significant 85th percentile for parents of all four groups of children with these disorders (Ross et al., 1998). As mentioned before, parental stress is associated with child abuse (Scannapieco & Connel-Carrick, 2004; Sullivan, 2003).

PCIT was found to be effective in decreasing maternal stress levels in one study (Timmer, Urquiza, Zebell, & McGrath, 2005). In this study of 135 parent-child dyads, significant decreases in stress, as measured by the PSI, Symptom Checklist- 90 (SCL-90), and Child Abuse Potential Inventory (CAPI) were found from pre- to post-treatment. This was found for both maltreated and non-maltreated children, for dyads in which the participating parent was the person who maltreated the child, and for dyads in which the participating parent was not the person who maltreated the child (Timmer et al., 2005).

In another study, Hutchinson (2006) examined the effect of PCIT in reducing total parent stress level. Data from the records of 17 parents who had participated in PCIT were examined. These parents had been given the PSI at pre- and mid- treatment to assess their level of stress. Mid-treatment point scores were used, rather than post-treatment scores, because a significant number of participants dropped out before completion of the entire course of treatment (Hutchinson, 2006). Paired samples t-tests were used to compare the levels of parental stress at these two time points. The scores were found to be significantly reduced between pre- and mid-treatment (Hutchinson, 2006). The reduction in the parents' total stress may be a reflection of parents feeling more of a sense of mastery over their parenting as a result of the new parenting skills they had learned. Parents' views of their child's level of misbehavior also were reduced. This reduction may reflect a change in the parents' belief that instead of misbehaving deliberately to annoy them, the child was not acting with provocative intentions. Finally, PCIT's effect of actual reductions in child misbehavior may be related to lowering of parent stress levels.

These preceding studies represent some of the initial efforts in PCIT research to establish it as an efficacious treatment for improving child behavior and reducing parent stress and abuse potential. The significant findings support the conclusion that PCIT impacts child and parenting behavior and yields significant improvements in child functioning over time. However, these studies were limited by methodology in that those who attrite from treatment are not necessarily able to be included in outcome comparison, thereby likely conflating results to be more positive. In addition, the early research was conducted typically in standardized PCIT treatment facilities, most often in university research clinics; thus generalizing to more natural settings is questionable.

PCIT with diverse groups. As evidenced in the review of the following literature, a major thrust in recent PCIT research has been applying PCIT to varied populations and settings. Tailoring it to meet the unique needs of the various groups receiving PCIT often entails modifying PCIT in some manner. A problem with modifying the treatment is that PCIT is a well-researched manualized treatment. Therefore, changes in the treatment may affect its validity and compromise treatment efficacy. In response to the research initiatives adapting PCIT to various populations, the primary formulator of PCIT, Sheila Eyberg, addressed what is essential to PCIT integrity and how PCIT can be adapted without compromising this integrity (Eyberg, 2005).

Eyberg (2005) identified one of the primary theoretical underpinnings of PCIT, that of fostering authoritative parenting practices, as being one essential component of PCIT. Eyberg stated that "authoritative parenting," a term originally expressed by Baumrind (1967), consists of parents providing nurturance and firm limits. Coaching parents in authoritative parenting practices is done during the different phases of PCIT, the child directed phase (CDI), during which the parent follows the child's lead during play, and the parent directed phase (PDI), during which the parent leads the activities. This sequence of phases is another unique and essential feature of PCIT. Therapists coach parents throughout PCIT sessions to support the child and help the child meet parent expectations (Eyberg, 2005).

In vivo coaching of parents in authoritative parenting practices also represents an essential feature of PCIT (Eyberg, 2005). The coaching is based in behavioral principles, both in terms of the parent's shaping of the child's behavior, but also in the therapist's shaping of the parent's behavior. The parent provides positive reinforcement to the child through praise,

expressing verbal and physical attention towards the child, and demonstrating enthusiasm. The therapist also models these behaviors during parent coaching by praising the parent when she performs the target behaviors and reshaping inappropriate behaviors (Eyberg, 2005).

Other researchers (Budd, Lyon, & Gershon, 2010) also identified core elements of PCIT. One feature is that PCIT is data driven, utilizing standardized instruments for feedback for parents in their use of target parenting behaviors. Parents are assessed at the beginning of each therapy session by the therapist and the total positive and negative behaviors are coded and tallied. Parents have target goals for each subset of behaviors, with mastery targets to advance in treatment. One of the core features of PCIT that was identified is that authoritative parenting practices are fostered (Budd et al., 2010). Also, the sequence of PCIT begins with the CDI phase and then progresses into the PDI phase in order to foster the parent-child relationship initially. Two additional core features are that therapists coach parents in vivo and standardized assessments are used for feedback (Budd et al., 2010).

Eyberg (2005) also described conditions in which a treatment, in this case PCIT, may need to be changed. She stated that first, a component of treatment may need to be altered, because this alteration would be anticipated to prove more beneficial for the target population. She termed this type of change "tailoring," in which a component of treatment is altered to benefit the target population. Tailoring a treatment is done if it makes the treatment more appropriate for a target population, but it is still possible to use most of the original treatment (Eyberg, 2005). An example of this is modifying the instructions of PCIT when used with clients with limited cognitive resources. Here the instructions given to the client are similar to

the original instructions, but the wording is verbalized using elementary language for the client to understand.

Another reason a treatment would be changed is if the specified conditions of treatment are unavailable, such as if the ear bug for the therapist to coach the parent is unavailable. Eyberg stated that this type of change is a "modification" (2005). A modification could likely be necessary in settings outside of the typical PCIT clinic, such as in in-home PCIT settings. Here the one-way mirror is unavailable and the therapist sits in the same room as the parent and child. Because both tailoring and modifying PCIT may alter the treatment, a goal should be to validate the treatment with these changes to ensure that modifications have not compromised treatment efficacy. Thus, an alteration of treatment may help meet the needs of the population or researcher and still remain faithful to the original treatment if the core elements of the treatment remain intact.

Most of the current PCIT research has been focused toward applying PCIT to different groups and settings. In doing so, researchers must be mindful of the above-discussed considerations concerning altering treatment and retaining the original features of PCIT. PCIT has been found to be effective with a number of special populations, as will be illustrated shortly. Researchers have shown that PCIT can be applied to foster families successfully (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005). As cited in this study, 50 to 61% of children in foster care tend to exhibit disruptive behavior problems, compared to 10 to 12 % of children in the general population (The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001, as cited in McNeil et al., 2005).

There are a number of implications for this higher rate of behavior problems. Foster children with behavioral problems tend to stay in foster care longer, have numerous placements, move to residential treatment, and have unstable care. It is important to give foster parents the skills to manage this population of children with disruptive behavior problems. McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005) evaluated the effects of teaching PCIT to foster parents of children with behavior problems in a weekend format. The researchers administered the ECBI and a modified version of the TAI for foster parents to 27 foster families at pre-treatment and at one month after treatment. A significant decrease was found for child disruptive behavior frequency (ECBI Intensity Scale) and a significant increase in parental tolerance for their child's misbehavior (ECBI Problem Scale) was found. Foster parents were also highly satisfied with therapy (McNeil et al., 2005).

In a randomized control trial study of PCIT for children with disruptive behavior and mental retardation, researchers found that parents receiving PCIT with their children reported fewer disruptive behaviors at home than mothers on a waiting list (Bagner & Eyberg, 2007). The participants in this study were 30 mothers and their 3- to 6-year-old children with comorbid diagnoses of either mild or moderate mental retardation (MR) and oppositional defiant disorder (ODD). Compared to the control group, the parents in the group who received PCIT reported their children demonstrated significantly fewer disruptive behaviors as indicated by the Child Behavior Checklist, a parent-completed rating scale to assess child behavior problems, PSI Difficult Child Index, and ECBI Intensity Scale (Bagner & Eyberg, 2007). The groups did not differ significantly in the ECBI Problem Scale, PSI Parental Distress, and Parent-Child Dysfunctional Interaction subscales, all measures which generally indicate the amount of distress

parents experience as a result of their children's difficult behavior, indicating that treatment did not significantly reduce their level of distress felt about their child's behavior (Bagner & Eyberg, 2007).

It is interesting to note that the findings of this randomized control trial study are dissimilar to studies discussed previously, which tended to find significant decreases in child disruptive behavior, as well as parental distress. This discrepancy may be explained by the measures used to assess stress in this study not being sensitive to the unique issues experienced by parents of children with MR. Compared with a group of mothers of children with ODD without MR who had participated in another study by this group of authors, at pre-treatment, the mothers in this study with children with MR reported relatively less stress than mothers of children with ODD without MR (Bagner & Eyberg, 2007). The authors noted a general tendency of mothers with children with MR to have less stress as a result of their child's behavioral issues, perhaps due to attributing the behavior to cognitive issues or focusing on other forms of stress not covered in the PSI (Bagner & Eyberg, 2007).

Another area that has been increasingly studied lately concerns the effects of PCIT when applied to minority families. In a review of some of the literature on the application of PCIT to minority families in the United States, Butler and Eyberg (2006) noted that PCIT has been shown to be effective with African-American families. These authors also noted the need to standardize the ECBI for use with a variety of ethnic groups (Butler & Eyberg, 2006). Because there may be ethnic differences in how child behavior is viewed and accepted, it is important to adapt measures of appropriate child behavior to reflect cultural values.

A study which adapted PCIT for use with Mexican-American families and examined the results against standard PCIT found that there were no differences between the modified PCIT and standard PCIT; however, both were significantly more effective than treatment as usual, in this case therapists without PCIT training who provided one of several talk therapy oriented treatments (McCabe et al., 2005). The researchers concluded that standard PCIT is robust enough to be applied effectively to Mexican-American families. One difference that emerged was that Mexican-American families tended to participate in a greater number of sessions than non-Mexican-American families (McCabe et al., 2005). Researchers postulated that this was perhaps because of the emphasis on developing relationships over time efficiency in Mexican-American culture. The researchers advised clinicians to consider this factor when working with Mexican-American families (McCabe et al., 2005). The authors concluded by advocating for further research with varieties of minority families.

As PCIT has been applied to special populations, it has been modified from its original protocols. An example of PCIT being changed by including an additional component of treatment was described in a study examining the effect of a modified form of PCIT with children with Separation Anxiety Disorder (SAD; Pincus, Eyberg, & Choate, 2005). A frequent pattern exhibited by children with SAD and their parents is that the children exhibit anxiety when separating from their parents. In response to this, parents attend to this anxiety and in so doing, reinforce the display of anxiety as a mechanism for children to avoid separation from their parents. This often leads to further aversive interactions as parents resent their child's inability to separate. Based on the model of PCIT in which on-task behaviors are given attention and

tolerable negative behaviors are ignored, researchers reasoned that PCIT may be an effective treatment for SAD in children (Pincus et al., 2005).

During the course of the study, researchers gathered feedback from participating parents, who indicated that they would value learning skills to encourage their children to initiate new activities, a component not normally included in traditional PCIT (Pincus et al., 2005). Based on this feedback, the researchers designed a treatment component they termed "bravery-directed intervention" (BDI) to complement the other existing phases, CDI and PDI (Pincus et al., 2005). In BDI, therapists first taught parents about the cycle of anxiety, in which fearful separations are perpetuated and reinforced by negative attention from the parents. Therapists instructed parents that CDI skills could be used during these separations, and finally, separations should not be avoided, but instead, should be practiced with children.

Parents in the study practiced these skills with children during sessions in which artificial separation scenarios were contrived, and then planned a separation with children in the coming week, including a reward of spending time together after the separation. Researchers modified the coding instrument normally used during CDI and PDI to include anxious behaviors demonstrated by children during the separation task and targeted parent behaviors during this time (Pincus et al., 2005). Finally, therapists tailored the PCIT treatment slightly in the way they attended to certain behaviors during therapy. One way the therapy was tailored was by encouraging parents to allow children to lead play during CDI. This is ordinarily a typical goal during CDI, but based on the researchers' previous experience, parents of children with SAD tend to dominate the children's play during CDI, including solving tasks for the children and directing play. Thus, researchers were especially attuned to the level of autonomy parents were

granting children during CDI and providing additional praise when parents allowed children to dictate play during this time. Other ways the therapy was tailored, based on special needs of this population, included encouraging parents to not be hard on themselves after making a mistake during coaching, and encouraging parents to relax during the play period (Pincus et al., 2005).

Preliminary results of this modified PCIT intervention have shown that it is helpful in reducing symptoms of SAD in children between the ages of 4 and 8, compared with waitlisted controls (Pincus et al., 2005). The modification of PCIT to meet the needs of children with SAD illustrates that PCIT can be adapted to include an intervention targeting specific needs of the target population and that PCIT therapist behavior can be tailored to focus on specific needs of the clients. These changes in treatment did not appear to compromise the integrity of the critical aspects of PCIT, nor did they appear to compromise efficacy and, in fact, may have enhanced it for this particular group.

PCIT in diverse settings. The way in which PCIT is typically delivered has been through referral to a clinic specializing in PCIT, usually due to children's disruptive behaviors. The bulk of the research literature reflects this scenario. There are reasons, however, for wanting to examine the efficacy of PCIT as delivered in alternative settings, such as community mental health centers. First of all, for many families, this is a setting where they primarily or only receive mental health services. Reviewing studies with regard to ethnic minority youth and their families and their patterns of mental health usage, it appears that ethnic minority youth are less likely than non-minorities to seek and complete psychosocial services. When they do, it tends to be in community mental health settings (for a review, see Lyon & Budd, 2010). This suggests

that providing PCIT in an accessible setting, such as a community mental health setting, may reach a population that would not otherwise make use of this service.

In an effort to examine the efficacy of PCIT delivered in a community mental health setting, and to explore methods for instituting EBTs in this setting and reaching previously underserved populations, Lyon and Budd (2010) conducted a pilot study to examine the effect of PCIT which was provided in a community mental health center. Children were referred to this particular mental health center by a number of sources and came with a variety of diagnoses, including disruptive behavior disorders, ODD, ADHD, and autism. Seventy-nine percent received public assistance and all were ethnic minorities. Being a pilot study, the sample size was relatively small, with 12 families beginning treatment and only four completing it (Lyon & Budd, 2010). PCIT was administered in the standard manner and fidelity was assessed in terms of adherence to protocols. In addition, interventions designed to address barriers to participation were implemented, such as providing transportation vouchers and scheduling appointments outside of work hours.

Despite these efforts, Lyon and Budd witnessed a 67% attrition rate, which is higher than standard PCIT rates of 40-60% (2010). In an analysis of measured child behaviors and parental satisfaction, researchers found improvements in both domains from pre- to post-treatment, but with more attenuated changes among dropouts than treatment completers. Among treatment completers, half exhibited statistically significant decreases from pre- to post-treatment and had clinically elevated child behavioral scores at pre-treatment, while another family had significant decreases, but did not have initial clinically elevated child behavioral scores (Lyon & Budd, 2010). This finding was observed through post-hoc analysis of findings. Researchers attributed

the failure of the entire sample to achieve statistically significant declines to the lack of pre-treatment score elevation and not requiring diagnoses as inclusion criteria, such as is typically required in many research studies (Lyon & Budd, 2010).

In sum, this study illustrated that PCIT can potentially be used in a setting that is accessed by a number of families who often would not receive services in a traditional research center setting, where PCIT is often delivered (Lyon & Budd, 2010). While the findings did not demonstrate overwhelming efficacy for all families, it was promising that families who may not otherwise engage in PCIT due to barriers such as perceived stigma with engaging in PCIT, or not initiating services due to being overwhelmed with this process, were able to receive services, with some demonstrating statistically significant benefits. The treatment seemed to provide benefits to those participating, with trends indicating benefits among those who did not complete treatment (Lyon & Budd, 2010). Further research to improve attrition rates in this setting is warranted.

In an effort to reduce stigma associated with receiving mental health services and improve attrition rates, the delivery of PCIT services in the home is an area that has been increasingly explored by researchers. In an initial single-subject case study involving PCIT administered in-home, researchers found decreases in child negative behavior and parent negative parenting behavior, and increases in caregiver positive parenting behavior and praising (Ware, McNeil, Masse, & Stevens, 2008). Looking to expand upon this initial study, researchers sought to ascertain the effect in-home PCIT had on outcomes and attrition rates, compared with traditional clinic-based PCIT (Lanier et al., 2011). Researchers offered 120 families who were referred for PCIT the choice of in-home or clinic-based PCIT. Families participated in PCIT

receiving standard treatment methods. Although it was not specifically indicated in the article, it is assumed that families receiving PCIT in their homes received coaching feedback from the therapist in person, versus via an earpiece through a one-way mirror. The use of this practice illustrates the practicality of giving feedback in person, a consideration when PCIT is delivered outside of clinics, in environments without PCIT equipment. Participants were given measures normally used in PCIT research several times throughout treatment to assess child disruptive behavior, parent stress levels, and child symptoms (Lanier et al., 2011).

Lanier et al. (2011) reported that overall rates of improvement in child behaviors and symptoms occurred at comparable rates between in-home and clinic-based PCIT. On the other hand, parent stress levels improved at a statistically quicker rate when PCIT was delivered in the office. Researchers noted that some advantages of in-home delivery included elimination of barriers impeding participation, such as lack of transportation or time, and posited that in-home treatment may facilitate generalization of skills to a more natural home-based setting more fluidly. Disadvantages that were noted included that certain situations in the home could be disruptive to treatment, such as the presence of siblings, a concern that was minimized in the office (Lanier et al., 2011). In addition, the lack of privacy at times appeared to inhibit parents from fully accepting therapist feedback, such if they felt embarrassed about saying certain positive statements.

A resolution to this dilemma proposed by the researchers was to teach parents skills and provide coaching while parents were initially practicing the skills in an office, where parents would likely feel less inhibited, and then refine skills in families' homes (Lanier et al., 2011). In terms of effect of setting on attrition rates, researchers found no statistically significant

difference between in-home delivery versus in-office. This finding was surprising, given that it was expected that in-home delivery would improve attrition rates. A possible explanation for this unanticipated finding is that participants chose which setting they would prefer to receive services. Given that families were referred for services, and in some cases, mandated to receive services, participants had varying levels of motivation to participate. It may be that choosing to participate in the office instead of at home reflected a higher level of motivation among families, and that this was reflected in comparable attrition levels. Relevant findings from this study include that delivery of PCIT in natural settings and providing options of delivery settings for clients is likely as effective in delivering PCIT as in a more traditional way, and may make receiving services feasible for those clients who may otherwise not be able to attend these services (Lanier et al., 2011).

In an effort to examine the effects of in-home coaching sessions on the efficacy of PCIT, researchers conducted a study with families participating in PCIT with an experimental condition of adjunct at-home coaching services or a control condition of supplemental social support services (Timmer, Zebell, Culver, & Urquiza, 2010). All families who were referred for PCIT services were offered the opportunity to participate in this study. Eighty families were enrolled, with half being randomly assigned to the experimental condition and half being assigned to the control condition. Families who received adjunct at-home services had a therapist come to their home once a week for one hour to coach the child and parent during play time while the parent practiced PCIT skills. Those in the support services condition also had a therapist come to their home and observe their play time and receive feedback, but they did not receive in vivo coaching (Timmer et al., 2010).

Results of the study indicated that there were no significant differences between treatment groups from pre- to post-treatment in terms of improvements in child behavior or parenting behaviors, although both groups demonstrated significant improvements in both of these domains (Timmer et al., 2010). There were, however, significantly greater improvements in parents' tolerance of child negative behaviors and reductions in parent stress levels in the group of parents who received in-home coaching, as compared with those who received the social support. Researchers reflected that the in-home social support condition in which parents received feedback about their use of the PCIT skills was likely beneficial to learning PCIT, and suggested that having a control group that did not receive any in-home services would have been beneficial to examine the usefulness of the in-home coaching (Timmer et al, 2010). However, the reductions in parent stress levels and improved attitudes toward their children's behaviors were a demonstrated benefit from receiving the in-home PCIT coaching.

In a review of clinical considerations of providing PCIT in-home, Masse and McNeil (2008) first stated that in-home PCIT allows for less environmental control. Potential problems with this include distractions from the therapy process, the reduction in efficacy of time-outs if the child is able to engage in a pleasurable activity during this time, and possible bolting out of the home by the child. Suggestions to address these concerns include anticipating possible distractions in the environment, communicating and contracting with the parent to minimize distractions, and developing experience to problem-solve in the moment.

Another issue with providing in-home PCIT is the challenge of providing in-vivo coaching in person rather than through the earpiece and out of sight, as is typical in traditional PCIT. Problems with providing in-person coaching can be that the child is distracted by the

therapist or the child or parent feels inhibited to focus on the therapy. Strategies for minimizing this distraction include explaining to the child and parent(s) the purpose of the therapist being in the room and instructing them to ignore the therapist during sessions or ignore the child when sessions have begun. With regard to the therapist being in the room, a further challenge is that the child is less likely to be defiant when hearing the therapist providing instructions to the parent verbally versus the therapist providing instructions to the parent via the earpiece so that the child cannot hear. This condition creates artificial compliance from the child, as the child is not responding to the parent's technique, but rather to the therapist's presence, a response that will disappear when the therapist has terminated services. Attempts to address this may include arranging silent signals for the parent at predetermined instruction points, such as at transitions between activities.

Another concern with providing in-home PCIT is the cost effectiveness. For the family, there is likely less cost in terms of transportation and expenditure of time; however, this burden is then assumed by the therapist, who likely is required to travel to several clients' homes. A way to negotiate this concern is to strategically arrange client sessions in terms of proximity so that several clients in the same area can be seen during the same trip. Another possibility is expanding the length of the visits so that two sessions can be done at one time.

There are advantages to conducting therapy in the home that were discussed in the preceding articles. These include creating realistic scenarios in which clients can practice skills in a setting more similar to that in which they will likely use the skills. This likely enhances the clients' ability to learn the skill and apply it in real settings more easily than by learning the skills in the clinic.

PCIT has been adapted for use with groups to maximize training efficiency by providing the same training to several parent-child dyads simultaneously. One study examined the effect of a PCIT-influenced program administered in group settings for preschool age children with defiant behaviors, including aggression, destruction, or noncompliance (Pade, Taub, Aalborg, & Reiser, 2006). The program called TOTS was similar to PCIT in most respects, such as utilizing the same format of parents and children involved in play sessions together, while parents are instructed and coached in the same skills involved with PCIT. The TOTS program was modified from PCIT to better meet the needs of the population served. Changes were that overall treatment in TOTS was shorter than PCIT, but individual sessions were longer, which resulted in ten 2-hour sessions. Some of this time was also spent incorporating another aspect of the TOTS program, instruction of child temperament types and parent discipline styles as well. Also, as previously indicated, the TOTS program was conducted in group sessions, typically with five to seven children, each with their parent or parents. Seventy-three parent-child dyads completed treatment and were assessed in terms of child behaviors and parent stress levels before and after treatment; 23 of the dyads completed these same measures at a follow-up point approximately 5 years after completion of treatment (Pade et al., 2006).

Results indicated a decrease in problematic child behaviors and parent distress about problematic behaviors from pre- to post-treatment (Pade et al., 2006). When the scores of the 23 dyads completing follow-up measures at pre-treatment, post-treatment, and follow-up time points were compared, results again confirmed a statistically significant reduction in disruptive child behavior and parent distress with regard to disruptive behavior from pre- to post-treatment time points. When follow-up data were compared with pre- and post-treatment data, child disruptive

behavior was significantly reduced at follow-up points as compared with pre-treatment results, while no significant differences were found between post-treatment and follow-up data (Pade et al., 2006). These results suggest that reductions in child disruptive behavior tended to be stable across time. This sustained improvement was not found in regard to parent stress levels, as follow-up data was not significantly different from pre- or post-treatment levels, although reductions in levels at follow-up compared to pre-treatment were noted. These results also suggest that implementing a PCIT type program with young children who have begun to demonstrate concerning behavior in a school setting, utilizing a shortened PCIT format and incorporating other targeted material can be beneficial. In addition, conducting sessions in group sessions can be an effective way to reduce child disruptive behaviors and provide some benefits to parents.

Teacher-child interaction therapy (TCIT). Expanding upon the applicability of PCIT to various populations and for use in various settings, researchers have begun training teachers in PCIT skills. One of the most important reasons for utilizing PCIT among young children is that researchers have determined that the most prevalent mental health issue in this group is disruptive behaviors (Campbell, 1990). Additionally, 72% of teachers reported being displeased with the training they had received in managing disruptive behaviors in the classroom (Merrett & Wheldall, 1993). In one of the first studies to adapt PCIT for use by teachers, researchers (McIntosh, Rizza, & Bliss, 2000) examined how to adapt PCIT for use in the classroom through a single case study design, involving one student and one teacher. This study format allowed researchers to gather qualitative data and be flexible in working with the teacher to most

successfully adapt the therapy to meet her needs.

In this study, a child, 2 years of age, was referred by the school due to behavioral issues she displayed, such as biting, hitting, and kicking. One of the child's teachers was chosen to participate, as this teacher indicated she was having difficulties managing this child's behavior. The treatment began by coding the teacher and child interacting in three scenarios, as is standard in PCIT (McIntosh et al., 2000). The three scenarios are: the child leads the play, the teacher leads the play, and the teacher asks the child to clean-up. After coding, CDI and then PDI phases were begun, as is standard in PCIT. The teacher was instructed in the skills involved with each of these phases and then was coached in her use of these skills. The coaching took place in a room separate from the classroom, and involved the researchers coaching the teacher in direct interaction, rather than through an earpiece, as is typical in PCIT. The teacher was instructed to practice these skills during 5- to 10-minute special play time periods with the student in the classroom everyday between weekly TCIT sessions with the researchers (McIntosh et al., 2000).

The researchers (McIntosh et al., 2000) reported qualitative data they gathered throughout the study. Regarding the coaching sessions, the teacher stated that she found the live practice and coaching helpful, but that she felt she was doing something wrong when corrections were given by researchers. The researchers stated that they found it helpful to reassure the teacher that she was not doing anything wrong, but that they were helping her to adhere to the PCIT protocols. When working with the child, the teacher commented that she noticed behavioral improvements almost immediately, as was corroborated with observational data, and that she felt her relationship with the child improved (McIntosh et al., 2000).

The teacher stated that during her special play time practice sessions with the child

throughout the week, it was difficult not to engage in some of the behaviors discouraged during PCIT, for example, to ask questions toward, criticize, or command the child instead of ignoring the child, as is encouraged during instances of child acting out. The teacher stated that she felt that if the child was behaving inappropriately to ignore the situation and not address it would only lead to further escalating negative behavior or could cause the negative behavior to occur in other situations. The researchers explained the rationale behind ignoring non-compliant behavior, that addressing it only reinforces this behavior through negative reinforcement, and that ignoring tolerable negative behavior (behavior which is off-task, but not hurtful), will likely extinguish displays of it (McIntosh et al., 2000).

During TDI, the teacher was instructed to give the child a direction and administer a procedure if the child didn't comply that consisted of giving the child a choice to comply or receive a time-out, and then administer the time-out for continued non-compliance. One observation that the researchers had was that some of the directions given by the teacher were too advanced for the child because the teacher assigned tasks that involved multiple steps, without detailing each step, or the teacher used words that were too advanced (McIntosh et al., 2000). The researchers addressed this issue with the teacher and discussed the importance of crafting age-appropriate instructions so that the child could understand.

Data collected during observations of the child and the teacher's interactions at the beginning of each coaching session showed that the teacher's behaviors were more positive and that the child responded with less negative behaviors (McIntosh et al., 2000). The teacher used praise and descriptions more often and less questions and commands. The researchers discussed issues that arose in the implementation of TCIT (McIntosh et al., 2000). The first issue was that

during coaching sessions, when the teacher, child, and researchers were away from the classroom, it was necessary to arrange coverage for the remaining students. This was accomplished by working with other teachers or aides to cover for the teacher, scheduling training strategically so that the supervision of the students would not be demanding, such as during nap times or lunch, and scheduling training outside of regular teaching hours (McIntosh et al., 2000).

Another issue that arose was that some PCIT training seemed to conflict with previous training the teachers had received, such as how to effectively administer a time-out (McIntosh et al., 2000). Encouraging the teacher to adapt PCIT methods in order to achieve maximum efficacy, and stressing that her previously learned methods were not wrong, but were inconsistent with PCIT methodology was effective in helping the teacher adapt to the PCIT way. This particular teacher seemed receptive to adapting the unfamiliar PCIT techniques, but in circumstances in which a teacher feels strongly about the appropriateness of previously learned techniques, more direct instruction may be necessary (McIntosh et al., 2000).

Although this was only a case study and broad conclusions cannot be drawn from a single case study, the researchers in this study introduced the possibility of adapting PCIT for use in the classroom as teacher-child interaction therapy (TCIT; McIntosh et al., 2000). PCIT techniques seemed readily adaptable for use by a teacher, with little change in the approach used in developing these skills. The format of this study allowed researchers to garner subjective impressions of the teacher, which may prove instructive when implementing TCIT further (McIntosh et al., 2000). It seemed important to address previous training the teacher had and acknowledge its value, but also to discuss the differences and why PCIT techniques are used. It was helpful for the teacher to witness success with the PCIT techniques early, and pointing out

successes when working with those with previous training may be helpful in encouraging these people to be invested in learning PCIT. TCIT was helpful in this case for reducing disruptive behaviors in this child and helping the teacher to feel more confident in her approach with other students (McIntosh et al., 2000). The success of this initial study led to further research, which will be discussed as follows.

Interventions designed to implement with an entire classroom are desired to maximize teacher efficiency in negotiating problem behaviors with a classroom of students. Researchers compared two programs for managing classroom behavior: a token economy-based level system and a PCIT training program in a preschool classroom (Filcheck, McNeil, Greco, & Bernard, 2004). This particular classroom was chosen because child behavior issues and teacher management were deemed problematic. Researchers worked with the teacher of this classroom of 17 students, with a mean age of 2.9, to implement both systems. Teacher and student behaviors were observed and coded before the systems were introduced. The level system was implemented and behaviors were coded. The level system was withdrawn and behaviors were coded. Then PCIT was introduced and behaviors were coded. PCIT was withdrawn and behaviors were coded. In addition, behaviors were coded at a follow-up time 4.5 months after completion of the initial study. Treatment fidelity was assessed via adherence to treatment manual checklists (Filcheck et al., 2004).

The particular level system used in the study incorporated a chart at the front of the classroom with seven levels; three were considered positive levels, three negative levels, and one neutral level (Filcheck et al., 2004). Teachers move students to various levels based on students' behavior, moving them in a direction toward positive levels for appropriate behavior, such as

following directions, or moving them toward negative levels for continued noncompliance after being warned to follow instructions or after egregious behavior, such as hitting. Students are given rewards at various points throughout the day for being in positive levels (Filcheck et al., 2004).

Both CDI and PDI PCIT skills were taught to the teacher via typical didactic means (Filcheck et al., 2004). The teacher was then coached through both phases in a typical PCIT setting, in a play therapy room with initially a single child, and then with two and three children as the teacher met mastery goals for one child in each phase. Upon meeting mastery goals in both phases of PCIT, the teacher was observed in the classroom and given immediate feedback with regard to her implementation of PCIT skills (Filcheck et al., 2004).

Results indicated an improvement in teacher positive behaviors, using more praise and less criticism of students, and a reduction in student negative behaviors after implementation of the level system (Filcheck et al., 2004). These behaviors further improved after CDI and PDI PCIT skills were taught. This suggests that both interventions are effective in managing classroom disruptive behaviors of students. The teacher also indicated she was satisfied with both systems.

When considering recommending either training teachers to implement a level system or PCIT, the authors of the article (Filcheck et al., 2004) considered the amount of training involved (4.5 hours with the level system and 11.5 hours with PCIT) and the needs of the teacher. They determined that for a teacher with good classroom management skills, but an especially difficult cluster of children, a level system would be a good choice due to less required training. For teachers who appear to have a deficit in skills, PCIT would be more beneficial due to instruction

in skills for managing students. For teachers with both an especially disruptive class and an apparent lack of skills, a combination of both PCIT training and training in implementation of a level system may be the optimal choice (Filcheck et al., 2004). The level of teacher skill can be determined through direct observation of the class and coding of teacher behaviors.

In a more recent study, researchers sought to determine the efficacy of TCIT as a preventative strategy for addressing problematic child behaviors and enhancing classroom interpersonal dynamics (Gershenson et al., 2010). The motivation behind implementing preventive interventions is to address problematic behaviors before they emerge by improving teacher-child relationships, thus reducing the necessity for later intervention when behaviors have become more entrenched and intervention may be more difficult. The potential of teacher-child relationships to impact child behavior is illustrated by research findings which revealed that negative teacher-child relationships are related to later child behavior problems (Brendgen, Wanner, Vitaro, Bukowski, & Tremblay, 2007). Gershenson, Lyon, and Budd (2010) sought to evaluate the effects of implementing a pre-school-wide TCIT program. This program was unique in the following ways: it took place in an urban setting with predominantly minority students, training took place with a number of classroom staff as a group, and all teachers at the school would participate. Another unique aspect was that there would be more observations and feedback provided to teachers about their use of TCIT skills while in the classroom than the traditional weekly PCIT feedback. In addition, researchers termed the program "Teacher-Child Interaction Training," rather than "teacher-child interaction therapy" to emphasize the preventative nature of the program. Researchers also stated as a goal that they wished to consider the systemic reaction of school personnel in the process of implementing this program

in the school (Gershenson et al., 2010).

Gershenson et al. (2010) first introduced the program at the pre-school during trainings about a variety of child development topics that they provided the school. This decision was based on the belief that for developing trust among teachers and for them to be invested in participating in the program, it would be necessary for researchers and teachers to know each other and for researchers to demonstrate their sincerity in wishing to help the teachers. When introducing the program, Gershenson et al. were also careful to address potential objections of teachers to participating in the program, such as the requiring of additional teacher time for training (2010). The researchers acknowledged these concerns and presented their rationale for introducing the program as being to prevent teacher burnout, thereby illustrating the advantage for teachers to participate. This anticipated benefit was based on previous findings in PCIT research, which has demonstrated reductions in parent stress levels, a result the researchers anticipated would generalize to the teachers. In addition, during training, trainers also relayed anecdotal evidence of the efficacy of PCIT to teachers, thereby encouraging the teachers to believe in the usefulness of learning PCIT. The researchers also took care to incorporate the program with minimal distress to the teachers, such as by scheduling trainings during naptimes (Gershenson et al., 2010).

The training of the teachers was similar to standard PCIT methods, with some changes. One difference was that a group of teachers was trained simultaneously by two trainers. The use of two trainers allowed one trainer to provide individualized attention to a teacher if necessary, without disrupting the training of the rest of the group. In the group setting, researchers included time and activities at the beginning of the program to build group rapport and teamwork, and

incorporated a graduation event at the end of training (Gershenson et al., 2010). The researchers expressed that because in future TCIT programs, participation may be mandated based on school administration adopting the program for use throughout the school, it was important to get all teachers involved in the training and invested in working together. In addition, role-plays were often conducted between lead teachers and teacher's aides to facilitate their working together when implementing PCIT in the classroom. The format of the training was also different. Typically in PCIT, didactic training with parents is limited to the first session. In this study, researchers provided eight 1½-hour sessions; during these trainings there was specific instruction in different PCIT skills, modeling of these skills, and role-playing, all of which are typically not done or emphasized to such a degree in typical PCIT (Gershenson et al., 2010).

Other changes employed by the researchers included adapting techniques to be used with a group of students, such as providing praise to an on-task student, while ignoring an off-task one, and conducting coaching sessions in the natural classroom setting, rather than an artificial therapy-room setting (Gershenson et al., 2010). The motivation behind these adaptations was to generalize the skills of PCIT as rapidly as possible for the teachers. After learning new skills, teachers practiced these skills with progressively larger groups of students, typically beginning with a small group, such as would occur during group projects and eventually applying the skills towards working with the entire classroom of 19 to 21 students. Researchers also adapted how they provided feedback. Normally in PCIT, feedback is provided instantaneously from therapist to parent via an earpiece. In this study, researchers provided feedback to teachers when it was possible to speak with them directly without disrupting teaching. This sometimes necessitated that researchers record feedback and review it with teachers at a later time so as not to disrupt

instruction time (Gershenson et al., 2010).

Another modification of treatment was that questions and commands were less restricted by the researchers (Gershenson et al., 2010). Typically in PCIT, participants are instructed to minimize or eliminate questions and commands so as to encourage children to lead play freely. In the classroom it is inadvisable to eliminate all questions or commands, as the teacher is responsible for guiding children through activities and facilitating programming. The researchers instead instructed teachers in the rationale behind avoiding these behaviors and encouraged teachers to avoid questions and commands when possible, such as during free play activities (Gershenson et al., 2010).

Teachers were also instructed to use alternative PCIT techniques in the classroom with the group. Typically during PDI, when giving a command, parents are instructed to address child non-compliance by giving the child a choice between complying or receiving a time-out. In this study, researchers encouraged teachers to use other strategies, such as reminding children they could receive preferred rewards for compliance or having teachers provide physical support (Gershenson et al., 2010). Teachers also worked with researchers as a group to generate a customized procedure for child noncompliance. This resulted in children being asked to "sit and watch," rather than being asked to take a time-out.

The researchers evaluated the effects of this program through observation of teacher behaviors at multiple points throughout program implementation (Gershenson et al., 2010). Results indicated that ten teachers demonstrated significant improvements in use of one target skill, five used more than one skill significantly more often than before training, and two showed no improvements in use of skills. Teachers also rated training highly, according to researchers

(Gershenson et al., 2010). Quantitative data was not reported for either teacher observations or teacher ratings.

This study illustrates several important factors to consider when implementing a program, such as PCIT, in an existing agency. First of all, the researchers focused a great deal on establishing a relationship with the school and personnel. They explained the program and its rationale, conducted a number of activities and discussions to facilitate cooperation, and made efforts to minimize the intrusiveness of the program (Gershenson et al., 2010). Secondly, teaching PCIT in a group format with longer didactic sessions and coaching in the natural setting of classroom teaching via personal feedback helped implement the program quickly and efficiently. Finally, researchers also noted that when implementing this program, a number of naturally occurring obstacles arose, such as short teacher staffing and working with teachers with a range of education and experience. The researchers stated that they were able to successfully negotiate these and other difficulties as they arose with minimal disruption in program implementation (Gershenson et al., 2010).

Staff-child interaction therapy (SCIT). An adaptation of PCIT that is likely most similar to that for a camp setting is staff-child interaction therapy (SCIT), a variation of PCIT intended for training residential staff. In addition to PCIT skills, SCIT also incorporates strategies for group behavior management, as residential staff members are normally responsible for supervising more than one child. Researcher Gus Diamond (2010) described how PCIT was adapted to train residential staff responsible for the therapeutic care of children between the ages of 4 and 8. Although the diagnoses of the children in residential care at the facility were not

provided, according to Diamond, many of the children had been moved from previous placements because of disruptive behavior, and/or were not able to be placed in family settings because of disruptive behavior, and were on psychotropic medication (2010). Implementation of the SCIT program began with an observation period of residential staff with the children. During this time it was found that staff used zero praise behaviors when working with the children, a skill that is a main focus of PCIT and has been found useful in working with children. It was thus determined that staff would benefit from training in PCIT skills (Diamond, 2010).

Researchers began by training residential staff supervisors at the residential center, who would in turn train residential staff (Diamond, 2010). This was done because staff turnover at residential facilities is typically high and would allow these onsite trainers to train new childcare workers. In training the trainers, researchers first instructed trainers to read the PCIT training manual. Then a researcher conducted a didactic training session, instructing trainers further on PCIT. Trainers then watched videos demonstrating actual PCIT sessions. Researchers then coached trainers in their use of PCIT skills with residents in both the CDI phase and what would normally be termed the PDI phase, but was instead renamed "SDI" to reflect that staff was leading the session rather than parents (Diamond, 2010). Trainers continued being coached by researchers until they demonstrated mastery criteria, similar to typical PCIT, in both CDI and SDI phases. Researchers then conducted two additional didactic training sessions on the topic of coaching residential staff, along with several booster sessions when trainers began training other residential staff (Diamond, 2010).

Residential staff were trained and coached in ways similar to parents with additional training at the beginning. Staff members watched a video describing PCIT; it was reported that

staff found this helpful due to flexibility in being able to watch it when was best for them (Diamond, 2010). An initial meeting was scheduled between trainer and residential staff, much in the same way that parents and therapist meet before working with the child. During this time, PCIT techniques are discussed and practiced, in a manner similar to PCIT.

One difference between SCIT and PCIT is that during this time, staff members are instructed in how to implement homework during the coming weeks by choosing a child in their care and scheduling a typical 5-minute play practice session. Trainers then coached staff attempting to use new PCIT techniques. This training takes place in a typical PCIT environment, consisting of a one-way mirror with residential staff and child on one side playing with select toys, and trainers on the other side of the mirror communicating with staff via a one-way earpiece. Trainings typically take place weekly. Beginning each session, trainers code staff behaviors in three scenarios to determine if staff members are meeting PCIT skills goals (Diamond, 2010).

Once staff members met mastery with one child, another child was introduced in the playroom during PCIT sessions (Diamond, 2010). This was done to more accurately reflect actual conditions staff will typically encounter, working with multiple children. PCIT skills were modified at this time to encourage staff members to focus on the child making appropriate choices. For example, if a child were to throw toys, staff might praise another child who is playing with the toys appropriately. When the disruptive child begins behaving appropriately, staff members then praise him for returning to appropriate play.

Upon meeting CDI mastery goals when working with two children, SDI phase is begun. During implementation of this phase in the study, researchers found that children selected to

participate in coaching sessions with staff members reveled in the individual attention and would often not exhibit improper behaviors in a one-to-one setting with staff members, which would allow staff members to practice discipline behaviors (Diamond, 2010). Therefore SDI skills were practiced with another staff member role-playing the role of a defiant child, allowing new staff members to practice time-out administration procedures.

Another modification of typical PCIT involved coaching within the actual residential milieu (Diamond, 2010). This was to address what was described as "fireman syndrome," in which during periods of relative calm on the milieu, staff typically supervise children from a distance, much as a firefighter waits at the station, and only address children when they are being disruptive to go "put out fires." The problem with this approach is that staff members may feel this approach is successful because the children typically cease the disruptive behavior. However, they are actually providing negative attention to the disruptive child, thus perpetuating the cycle of acting out. Instead, staff members were coached to circulate among the children during activities and use their PCIT skills to provide positive attention to children behaving appropriately (Diamond, 2010). This positive reinforcement can be combined with token reinforcements, such as a sticker system to reward on-task behavior, leading to a prize upon children meeting target goals. Finally, trainers worked with staff members to help ensure that they provided attention and supervision to multiple children who were in their care to help maintain general order in the milieu, a consideration that is less salient in PCIT, where parents typically focus on one or very few children exclusively. Staff members were encouraged to communicate these coverage considerations to other staff members to cooperatively work with the children (Diamond, 2010).

Diamond found a number of positive effects after implementing the SCIT program in this residential facility (2010). There were anecdotal reports of staff members and children enjoying themselves during activities, no timeouts, a large number of praises, and few redirections from inappropriate behavior. Researchers also interviewed staff members, who reported less feelings of stress and more satisfaction with their jobs, feelings of improved relations with the children, and feeling more confident in their abilities to work with difficult children (Diamond, 2010). As a result of these initial findings, the residential program elected to implement SCIT throughout their various programs. Staff members are reassessed for skills every two years and provided booster sessions if targets are not met. Monthly coaching sessions in the residential unit were reported effective for maintaining proficiency in the skills (Diamond, 2010).

A major limitation of this study was that there were no quantitative results reported. The researcher did not indicate if these would be reported later and a subsequent search did not yield any other findings of research in SCIT. Given these limitations, it is premature to conclude that SCIT is an effective training program for residential staff. However, a number of findings are instructive in adapting PCIT to assist professionals working with children. First of all, the main methods used in PCIT were not substantially altered when introducing modifications. Instruction was provided to staff, they were coached, mastery goals were met, and there were subsequent follow-up sessions (Diamond, 2010). The addition of components that were suited to the residential milieu did not seem to detract from these main components. This would suggest that it is possible to incorporate changes to meet the needs of childcare workers while maintaining PCIT efficacy.

Second, information gathered from anecdotal reports and staff interviews suggests that this program was helpful in working with children and was well-received by staff members, providing support that this is an effective way to train staff in working with children (Diamond, 2010). Third, though training procedures typically used to train staff at this residential program were not indicated, this training did not seem to create an exorbitant burden upon staff or the agency in terms of resources, such as time or money, as evidenced by the agency adopting this training method in light of indications of a limited budget (Diamond, 2010). In light of these considerations, it seems that SCIT is a promising process for training childcare workers in using evidence-based techniques for working with children. This training process should be researched further and may be incorporated into similar settings.

In an effort to standardize PCIT delivered in group settings to encourage best practices, a manual for group PCIT was developed by researchers, including the original formulator of PCIT (Eyberg et al., 2009). Much like the original PCIT manual, the group PCIT manual guides the therapist through the delivery of PCIT. A difference between group PCIT and traditional PCIT is that in group PCIT, the parents who are not being actively coded or coached will remain in the viewing room with a therapist and all observe the parent-child dyad that is being coached. This coaching occurs with another therapist in the same room as the parent and child. This allows parents not being coached to learn through vicarious learning as they observe the parent-child dyad being coached and discuss this with the therapist.

As suggested in the first difference, a second difference is that there are two therapists in group PCIT instead of one therapist, as in typical PCIT. Third, depending on the number of participants in the PCIT group, not all parents will be coached each week; however, every parent

will be coded each week. Parents are scheduled to be coached in a rotation ensuring a fair distribution of coaching sessions. Fourth, the group will begin the PDI teaching session when at least 50% of the parents have met mastery in CDI phase; however, parents who have not yet met CDI mastery will need to do so to graduate from the therapy. These parents will continue to be coded in CDI and receive therapist feedback in CDI coaching sessions before attempting PDI skills, although they will be present for the PDI instruction provided to the entire group. Finally, therapists work with families on performing PCIT in different situations, such as in public, by teaching them skills that may be used when in these situations and role-playing these scenarios in the therapy room.

Because this manual is relatively new, Eyberg et al. (2009) are still researching the efficacy of group PCIT. The researchers reported in the manual that according to preliminary data, group PCIT appeared effective in reducing child negative behavior, increasing child positive behavior, increasing parental positive behavior, and decreasing parental negative behavior (Eyberg et al., 2009). The group PCIT manual will be described in more detail in the Program Description chapter of this dissertation, when various components will be adapted for use in a camp setting.

Training methods. Researchers have increasingly been investigating training methods to ascertain the most efficient manner of training therapists in PCIT. Herschell, Kolko, Baumann, and Davis (2010) reviewed the existing literature concerning therapist training methods in studies from 1990 to 2009. The first training method reviewed was training through manuals. The researchers found that utilizing training manuals may be necessary, but is not sufficient for

trainees to gain mastery. Trainees typically gained knowledge through reading materials, but these gains tend to be short-lived and less than gains from other methods (Herschell et al., 2010).

The next training method that was reviewed was self-management training, in which trainees reviewed a video (Herschell et al., 2010). These trainings tended to yield favorable reviews from trainees, were cost effective, and increased knowledge. However, the efficacy of this modality was dependent on trainee characteristics, including trainee motivation to learn, and how engaging the training material was. A third training method, workshops, such as those utilized when providing continuing education for professionals, was found to yield some increases in participant knowledge; however, on the whole, impacted participant behavior, attitude, or application of skills very little (Herschell et al., 2010). There were findings of increased use of targeted skills, but these behaviors disappeared shortly after the workshop. In terms of the length of workshops, 1- to 3-hour workshops were found to yield no change in skills or knowledge. Workshops longer than this were found to yield benefits, but the length of the workshop did not correlate with increased benefits, suggesting that at some point, participants stop learning, possibly due to saturation or fatigue. Workshop supplements, such as observation and feedback, were found to be effective in training trainees in new therapeutic skills (Herschell et al., 2010).

Conducting role plays and providing feedback in a variety of situations that the trainee is likely to encounter was especially helpful for trainees to gain skills and retain them (Herschell et al., 2010). Train-the-trainer was a relatively little researched method, and methodologies employed in these studies were not rigorous. However, there was some suggestion that these methods are promising. The most promising training method overall seemed to be a

combination of the above methods, including manuals, self-instruction, workshops, role-plays with feedback, and train-the-trainer methods, into one multi-method training, including practice of techniques in role plays. Using this approach, 19 out of 21 studies reported significant improvements in trainee aptitude upon completion of the training, however due to differences in the content of training programs among studies it is difficult to make comparisons (Herschell et al., 2010). The finding that 19 out of 21 studies using multi-method approaches with hands-on training resulted in improvements in trainee knowledge and use of trained skills suggests that this approach is a superior method of training for the retention and utilization of learned information by trainees.

Researchers have been evaluating ways to teach PCIT to clinicians to determine the most efficient and efficacious manner of teaching them (Herschell et al., 2009). Herschell et al. (2009) sought to determine the effect two methods of training had on clinician learning of both PCIT techniques and coaching these techniques as a PCIT therapist. Forty-two participating clinicians were randomly assigned to one of two different learning groups. In both conditions, participants read the training manual and received didactic instruction. Instruction was done via presentation by the researchers, live modeling, and via video. Next, half the participants then received another didactic session, and half were trained experientially. Participants in the second didactic session reviewed video-taped sessions of PCIT performed with clients, coded video-taped PCIT sessions as a group, and discussed PCIT skills. Participants in the experiential group participated in role plays, coded sessions individually, and received frequent and individualized feedback about their performance (Herschell et al., 2009).

The main differences between the learning groups were that the didactic group did not receive live coaching or coding feedback about their performance from researchers (Herschell et al., 2009). Participants were assessed before training, after reading the manual, after the first didactic session, and after the final training. Participants were assessed in terms of their satisfaction with the training, their knowledge gained, and their performance of PCIT skills and of PCIT coaching. Training took place over one weekend and only focused on CDI skills and coaching and not PDI skills and coaching, which is considerably shorter than typical training in both PCIT and PCIT coaching (Herschell et al., 2009).

Results indicated that participants gained knowledge about PCIT skills and PCIT coaching after reading the treatment manual, although not at mastery levels (Herschell et al., 2009). Next, to compare the didactic and experiential groups at points before and after either of those trainings were given MANOVAs were conducted for each of the domains being assessed, skills acquired, knowledge acquired, and training satisfaction. Results indicated that for each of the domains assessed, there were no group or group x time differences, but there were time differences, with participants improving in PCIT skills, knowledge, and satisfaction with training from before the second training to after the training.

Results of this study suggest that reading a treatment manual may be helpful for gaining some knowledge, but is likely insufficient to attain proficiency in the target treatment. In addition, use of didactic and experiential training seems to be effective in improving trainees' skills, knowledge, and satisfaction with training, although it is surprising that didactic and experiential training appeared to impact these areas equally, as experiential training is considered an important component of PCIT and necessary for skill mastery. Herschell et al. (2009)

explained that perhaps this lack of difference was an artifact of the study construction, with participants in the didactic training receiving significant instruction through video examples, discussion, and live modeling. In addition, although participants did not receive feedback at these times, they all participated in three skills assessments in which they performed PCIT, perhaps enhancing their learning of the treatment through practice similar to a role play. Although both groups made significant improvements in their PCIT skills and knowledge, relatively few demonstrated mastery of PCIT skills and coaching (Herschell et al., 2009). This suggests that a 2-day training for PCIT may be insufficient for participants to gain mastery over PCIT skills and coaching skills; however, if the 2-day workshop were limited to training in PCIT skills only and not coaching skills, the amount of people achieving mastery of PCIT skills may be improved.

Theory of wilderness therapy camps. The use of outdoor activities to address the unique needs of youth with special needs represents some of the earliest attempts to provide therapeutic interventions to this population. A brief history of the development of outdoor therapeutic programming illustrates the theoretical rationales of the formulators (Berman & Davis-Berman, 1995). Initially in the early 1900s, there was a belief that fresh air was a key factor in the residents' rehabilitation at psychiatric hospitals. Consequently, tents were arranged on hospital lawns for residents to camp. Although there was anecdotal support for the initiation of this approach, no conclusive evidence of its efficacy was ever garnered (Berman & Davis-Berman, 1995).

Fritz Redl was one of the first to establish therapeutic camps as a method for working with youth who have mental health issues. He came to work at the University of Michigan Fresh Air Camp, a therapeutic camp for "troubled" (specific diagnoses were not specified) youth established in 1921 (Beker, 1991). Redl and others emphasized the importance of the entire camp milieu as being therapeutic for attending youth. He believed that an integral part of the milieu was the counselors. He arranged for the counselors to speak with youth in his development of the life-space interview, a way of addressing youth behavior by counselors that occurs in the moment. The emphasis of the life-space interview was on helping the youth to develop awareness of their behavior and returning them to programming quickly. Redl also was aware of the potential damage that could result from therapeutic efforts and espoused the maxim that the first mandate of those working with vulnerable youth is that no harm should be done with these youth. Finally, he also emphasized the importance of constructing appropriate activities for youth so that they would not construct their own inappropriate activities (Beker, 1991).

In the mid-1900s, more targeted approaches toward mental health treatment were incorporated in outdoor treatments. In the contained setting, staff members could formally observe campers, provide diagnoses, and subsequently provide therapy. It was during this time that the notion of providing challenges to campers to overcome was introduced. This approach was reinforced through the widespread incorporation of the ideas of John Dewey and Kurt Hahn on experience-based learning to instruct young people. Hahn developed the Outward Bound program in the late 1940s, which is still one of the most recognized wilderness camps for youth (Berman & Davis-Berman, 1995).

The characteristics of Outward Bound, and other programs that emerged based on this model, are that there is a group, there are a series of challenges youth will encounter, and the programs are usually in the wilderness. In these programs, therapeutic techniques, such as journal writing or reflection, are used, in addition to traditional camp activities. Though there are these common factors, there are many variations in camps based on the needs of the youth and resources available (Kimball & Bacon, 1993).

The reason for the challenges is that Hahn contended that exposure to certain challenging situations tends to elicit pro-social values in the participants. In other words, young people will often come to develop, be aware of, and use skills necessary to complete challenges which require leadership, teamwork, communication, and problem solving, among many others. Related to this goal of youth learning pro-social values by completing challenging activities, wilderness camps also provide the opportunity for other types of experiential learning. Many youth referred for these programs have difficulties learning in the traditional educational or therapeutic context. Learning through written materials or didactic instruction requires attention and learning skills, which may likely be disordered in these youth or a source of difficulty. In wilderness camps, counselors may teach youth skills through activities or modeling, which may increase the likelihood of them being able to learn the skills (Russell, 2001).

Another therapeutic goal of wilderness camps is to provide youth with therapy through individual counseling, group counseling, and other modalities. The isolated setting reduces distractions, such as other people, technology, or environmental stressors, and enhances the opportunity for youth to focus on the therapeutic content. In addition, youth have the opportunity to reflect on this content and themselves in an unencumbered manner (Russell, 2001).

One of the rationales behind using the outdoor remote setting as a component of therapy is that the setting is often unfamiliar to the youth (Glass, 1993). In this different setting, youth may be more willing to form new means of interacting with others and be less adherent to previous modes of interaction. Additionally, they may feel slightly uncomfortable in the new and more natural environment and be more willing to accept help from others.

In contrast to the traditional format of talk psychotherapy, which typically involves a therapist and a youth talking in an enclosed office space, camp programs involve youth participating in activities, being physically active, and being with peers. For youth with emotional, behavioral, and learning difficulties, this more active engagement without the intensity of one-to-one interaction with a therapist may be more conducive to them being open and learning. Researchers have found that youth tend to spontaneously self-disclose more often in environments outside of the therapy office then inside it (Hanna, Hanna, & Keys, 1999).

Another way in which therapy is imparted upon youth is through the use of metaphor in the way the activities are designed. The use of metaphor has historical roots in systems work, especially in the psychodrama techniques of Moreno (Gillis & Gass, 2003). Thus, the important skill that youth are learning in completing a ropes course, for instance, is not the ability to scale gaps using ropes, but rather the understanding that through teamwork, problem-solving, utilizing psychic resources and coping skills, and other skills which are taught to youth, they are able to overcome challenges.

Wilderness Therapy Camp Research

As indicated above, wilderness therapy camps have a long history, but that has not been matched in output of research (Beker, 1991). The research that has been developed has involved describing the different types of camps, attempting to evaluate their efficacy, and determining the efficacious qualities of wilderness therapy camps. Some of this research will be reviewed and evaluated and the implications for this proposal discussed.

As the use of wilderness therapy camps continued to expand over time, they became more diverse in structure and focus. One difference among therapeutic camps is the manner in which therapeutic issues are addressed. The incorporation of therapy into camp structure can best be viewed along a continuum, from providing little to no therapy, to providing traditional therapy sessions. At one end of the continuum is little incorporation of therapy and a primary focus on recreation, in the middle are camps incorporating therapeutic techniques to address camper issues, such as behavioral interventions to keep campers engaged in activities, and at the other extreme are camps that provide organized therapy sessions.

Camps which are designed to focus on traditional camp activities are termed "recreational camps." The goal of these camps is primarily for the participants to have an enjoyable camp experience, although there are psychotherapeutic secondary gains to be had. Participants have been found to have learned new skills, such as social skills, have become more open to new experiences, have gained experience interacting with different types of people, and have experienced moral and character development (for a review, see Webb, 1999). Recreation camps which serve children with psychosocial issues and do not utilize any therapeutic interventions are rare (Crisp, 1998). Even camps whose primary goal is to provide a traditional camp experience

typically contain some psychotherapeutic components when serving this population of campers. For example, these camps may employ therapeutic techniques in order to keep the campers engaged in the programming.

A characteristic of recreation camps is the belief that the camps provide benefits for youth attending the camps beyond only a reduction in symptoms. Therefore, to evaluate the efficacy of these camps based on the reduction in disordered symptoms is inappropriate for a number of reasons. First, the intention of recreation camps is not to target and reduce the severity or occurrence of particular symptoms. Many recreation camps admit youth who may have difficulties functioning in a non-therapeutic camp, but who wish to attend camp and are in need of extra support to succeed. Due to the variety of reasons, youth may have difficulty attending a traditional camp; youth attending recreation camps are likely to present with a variety of symptoms and issues. This may make identifying and using specific treatments for these youth, as well as identifying the efficacy of these treatments, difficult due to the variety of symptoms displayed.

In addition, recreation camps may purposely avoid focusing on symptom reduction because it may be beneficial for youth to experience camp without focusing on their disorder. Throughout the rest of the year, youth with psychosocial issues may be continuously reminded of their issues through mental health services they receive, special treatment in school, and being treated in ways that remind them of their disorder by family and friends. Thus, it may be beneficial for them to be able to shed their label at the gates of camp and enjoy a camp experience as a youth without a diagnosis. For these reasons, it would be beneficial if camps contained therapeutic benefits that are not conferred through the same manner as traditional

therapeutic services, such as talk therapy. Thus it may be useful to consider the value of experiences, such as camps, in terms of enhancing the wellness of the participant or improving overall health.

Michalski, Mishna, Worthington, and Cummings (2003) studied the effect of a recreational style camp on youth with behavioral and learning disabilities. Many of the youth attending this camp had been to other camps and been dismissed for behavioral disruptions. At this camp, youth participated in a 3-week program that consisted of traditional camp activities, such as hiking, swimming, canoeing, arts, and so forth. There was a low staff member-to-camper ratio, and staff provided counseling to campers in groups as needed and consistent with camper needs and goals. The researchers sought to assess the impact the camp had on the youths' self-confidence and self-esteem, sense of isolation, and social competence. To assess each of these domains, the researchers administered child self-report measures, consisting of the Self-Esteem Index, the Children's Loneliness Questionnaire, and the Social Skills Rating System. They also administered a parent report measure, the parent version of the Social Skills Rating System (Michalski, Mishna, Worthington, & Cummings, 2003).

Forty-eight children ages 13 years and younger participated in one camp session and 48 adolescents ages 14-18 participated in another (Michalski et al., 2003). Both groups were assessed at pre-treatment, post-treatment, and at a follow-up point 6 to 8 months after finishing camp. Among the children, their overall self-esteem levels improved significantly from pre-treatment to post-treatment, their feelings of loneliness decreased from pre- to post-treatment and from pre-treatment to follow-up, and their levels of cooperation and self-control improved from pre-treatment to follow-up. Adolescents reported significantly less feelings of loneliness from

pre- to post-treatment, which extended to follow-up, approximately 6-8 months later. In addition, the adolescents reported increased feelings of self-control and assertion from pre-treatment to post-treatment. The majority of campers gave favorable ratings of the camp on a variety of measures, with the most positive rating indicating that the camp helped them to develop relationships with other attending youth. Parent satisfaction with the camp was generally high, although there was negative feedback in regard to the way they felt the counselors mismanaged conflicts, by doing too little, between their child and another child (Michalski et al., 2003).

Taken together, this study suggests that recreational camps may have benefits for youth with a variety of behavioral and learning issues. Because of these youths' inability to succeed in a traditional camp due to their special needs, they may not have had the opportunity to experience camp if not for the fact that this camp was able to accommodate them through the beneficial staff member-camper ratio, staff members' ability to work with campers in individualized ways, and modified programming. However, there were indications that techniques employed by staff members may be improved (Michalski et al., 2003). In addition, it was not clear if campers appeared to improve due to the fact that they attended camp, the modifications that were used at the camp, or whether improvements were an artifact of inaccurate assessment, due to the fact that instruments used to assess campers were self-report and parent-report measures, which may result in artificial inflated improvements. In addition, there were over 20 scales derived from the measures that were reported (Michalski et al., 2003). Not all of these were significant, and there was no adjustment applied to the alpha levels, possibly resulting in scores appearing significant by chance due to inflated Type I error.

Another example of enhanced wellness as a result of a camp experience is evidenced in a study conducted by Doucette, Ransom, and Kowalewski (2007, as cited in Brymer, Cuddihy, & Sharma-Brymer, 2010), in which high school-aged students participated in a 7- to 10-day summer camp with a focus on experiencing nature. The campers experienced improved self-confidence, improved self-reliance, and improved understanding of the benefits of social cooperation. Thus, experiences youth had in camp may increase wellness of participants, conveying benefits beyond symptom reduction.

The above reviewed studies examined benefits of recreationally-focused camps. More typically, wilderness therapy camping programs target campers' psychosocial issues by incorporating therapeutic approaches in the programming. Camps that employ a therapeutic approach typically assess the unique needs of individual campers via assessment measures, reports, and interviews before beginning camp. From these assessments, treatment plans are generated and therapeutic interventions tailored to implement this plan (Crisp, 1998).

Wilderness therapy camps are typically located in remote locations. Due to the change from participants' usual environments, a primary process emphasized is adaptation, in which participants utilize new skills to adapt to their environment. Wilderness therapy programs also typically contain the following components: goal-setting, trust building, fun, problem-solving, and challenges (Herbert, 1996). A number of therapy modalities may be employed, many considered alternative therapies, such as art and drama therapy, equine therapy, or horticulture therapy. Individual therapy tends to be the least used modality of therapy, likely because camp programmers prefer to utilize the camp group in therapy.

Fuentes and Burns (2002) surveyed existing wilderness camps to describe the types of camps available and their programs. Of the 35 camps (out of 89 contacted) returning surveys, approximately 83% were residential camps, with the remaining 17% both residential and non-residential. The three most popularly indicated goals of the camps were to rehabilitate the youth, reduce recidivism, and deter future crime. Ages of campers ranged from 6 to 26 years of age, but the majority of camps served adolescents 12 to 19 years of age. There was notable diversity in the reasons for youth referral, including status offenses, drug offenses, and behavioral issues, and including both violent and non-violent offenders, as well as first time-offenders and repeat offenders. The majority of camps reported that they target youth who have had a history of abuse, including physical abuse and/or neglect and sexual abuse (Fuentes & Burns, 2002). According to another researcher (Crisp, 1998), based on his extensive experience working in camps, his interviews with other camp administrators, and his discussion with other researchers, young males with behavioral issues and who are low-verbal and physically oriented tend to do best in therapeutic camps. This demographic also tends to be least successful in more traditional talk-oriented therapies.

In terms of services provided, 86% of the camps surveyed by Fuentes and Burns offered adventure activities, such as ropes courses, in addition to therapy or counseling; 80% had an educational component and 69% had drug counseling (2002). The following activities were offered, backpacking (91%), canoeing (80%), hiking (63%), rock climbing (49%), and assorted other camping activities were reported being offered at some camps. Camps reported that a typical week consisted of the following activities with their allotted percent of weekly time: traditional academic education (24%), outdoor skills education (23%), therapy (16%), counseling

(16%), and other camp activities filling the remaining time. There were an average of 38 employees at each camp, although the number at each camp varied based on the size of the camp, with only approximately six not having direct contact with the youth and instead employed in roles such as cooks and office personnel. In terms of staff level of education, approximately 47% of personnel held less than a bachelor's degree, 42% held a bachelor's degree, 9% held a master's degree, and 2% held a doctorate. The staff member-to-youth ratio was approximately 28:1 in terms of overall staffing levels, although that ratio includes all staff members, and does not reflect the true number of staff members working with the youth at given times and in given activities (Fuentes & Burns, 2002).

In the above cited study, Fuentes and Burns (2002) were somewhat hampered by a relatively low response rate. Because of this, the results may have been skewed because those responding my not represent the general wilderness therapy camp community. However, the study does help to provide a clearer understanding of what therapeutic camps look like. Some similar themes among camps emerged, including a focus on providing therapeutic services in these camps, a relatively high number of staff members to youth, and the fact that youth tended to reside at the camps (Fuentes & Burns, 2002). However, there was significant diversity among camps in a number of respects, in terms of size, staffing, youth served, and type of activities offered, among other factors. Thus, when planning training or programs for staff at these camps, it would be important to utilize methods which have either a range of applications, are able to be learned by a variety of people, and serve a variety of clients or are tailored for a specific population or camp.

Therapeutic camps often emphasize the group process, and concordantly, social gains are also a benefit of therapeutic camps. Often, camps emphasize the goal of developing cooperative skills and some even employ a contract in which youth agree to work together as a group. The activities with which the participants are tasked are often designed to require group effort to master. In a survey of adolescents who attended a therapeutic camp, helping other group members during activities was ranked as the most important experience the adolescents had at camp (Witman, 1993). By contributing to the group during activities, participants feel a sense of group belonging and have reported that they feel they are able to establish relationships and earn the respect of the group (Witman, 1993). Results from this study must be considered with caution because, though the researcher surveyed the adolescents and assured them their answers would remain anonymous, the prospect of their answers being viewed may have influenced the adolescents to respond more favorably than would otherwise actually be the case.

Designing camp activities to provide a challenge for campers to overcome was found to typically yield benefits in the following areas, based on a review of existing studies of wilderness therapy camp efficacy: developing an internal locus of control, increasing self-esteem, and developing appropriate interpersonal skills (for a review, see Wilson & Lipsey, 2000). Typical activities may include rock climbing, therapeutic camping, overnight solo experiences, and family programming (Roberts, 2000). As youth participate in these activities, they benefit through mastering both the physical activities and their interpersonal interactions. As the participants conquer physical challenges, they may feel a sense of accomplishment and subsequent increases in their self-esteem and in their self-control through their realized efforts.

Many of the challenges are designed for youth to participate in with other youth. By working together, they learn cooperation, communication, and other interpersonal skills.

In a meta-analysis on the effect of the camp experience on youth self-esteem, Marsh (1999) found that youth who attended camps that had a focus on self-enhancement had greater self-esteem after attending these camps than before attending. These effects were especially pronounced for pre-teens. It is not exactly clear what components contribute to participants' increased self-esteem and through what mechanisms the participants' sense of self-esteem is increased. Is it the activities, the interpersonal contact, or perhaps the content of the camp, such as counselors delivering messages about self-esteem and providing praise that led to increases in self-esteem?

Another way interpersonal contact benefits youth is through the relationships they develop with the staff members. It has been established in psychotherapeutic research that the therapeutic alliance, the quality of the relationship between the therapist and the client, is the most significant predictor of therapeutic success. It stands to reason that it should be a goal to enhance the therapeutic relationship between counselors and children to create the most favorable conditions for the child to experience therapeutic benefits from the therapeutic camp.

In a study assessing counselors at a wilderness camp and the attending youths' perceptions about their therapeutic relationships with each other, researchers found a great deal of disagreement between the groups' views of their relationships with each other (Bickman et al., 2004). Youth and counselors were assessed for their perception of the amount of empathy, collaboration, and help the counselor gave the youth using the Therapeutic Alliance Scale (TAS). There were significant differences in the way the youth and counselors viewed their relationships.

Typically, the counselors viewed their therapeutic relationships with the youth as being closer than the youth viewed their relationships as being with the counselors (Bickman et al., 2004). The fact that there was a difference in the way the counselors and youth perceived their relationships suggests that counselors may not be aware that they are relating interpersonally with youth in ways which youth do not view as favorable.

In addition, researchers found a modest correlation among youth rankings of specific counselors, indicating that some counselors were consistently viewed as more favorable in terms of relationship with youth than other counselors (Bickman et al., 2004). This suggests that there is variability in counselor interpersonal behaviors with youth, which may be enhanced through training in specific relationship-enhancing skills. It would be important to implement training in these skills proactively because, as was suggested by the study, counselors may not view that there is a deficit in their therapeutic interpersonal skills and thus they may not ask for training in these areas.

The approach to managing behavior at therapeutic camps typically consists of employing a level system (Crisp, 1998). Levels are based on campers' behavior and progress toward goals. These levels are frequently reviewed with rewards and consequences administered as warranted. Interventions are typically managed by staff as stipulated by the mandates of the level system, such as providing warnings before consequences or giving choices to campers. However, at smaller camps, typically more experienced and qualified staff members were present, campers were assessed more thoroughly and interventions shaped by this assessment, and therapy more individualized. According to the Crisp, who based his conclusions on observations of camp activities conducted at camps, interviews with camp personnel, and discussion with other

researchers, these types of camps typically resulted in more rapid progress for campers towards treatment goals (1998). However, this assertion has not been evaluated empirically. As with any level system, the generalizability of a level system to outside the camp is questionable. Would parents have to continue this system or would the youth internalize these values? Because there is so much variability between types of level systems and their implementation, answering this question conclusively depends on the specific level system used.

Another feature of therapeutic camps is that they often take place outside in nature. In a review of the literature concerning the effect of nature-based experiences on wellness, researchers concluded that nature positively affects emotional, physical, and intellectual wellness in a variety of ways (Brymer et al., 2010). The researchers found that across a variety of studies, exposure to nature led to improved emotional well-being, reductions in stress, increased positive mood, enhanced life skills, reductions in mental fatigue, increased concentration, and reductions in aggressive behaviors. The researchers postulated that these improvements may be due to nature being mentally refreshing for campers, triggering deep reflections, providing an opportunity for individuals to attend to their own well-being, and providing campers with a sense of connection with the world. The researchers noted that exposure to virtual nature (a video of nature) or being outside in an urban setting without nature did not confer the same benefits to such a degree as being in actual nature (Brymer et al., 2010).

In one of the first empirical studies on wilderness therapy camps, Davis-Berman and Berman (1989) sought to evaluate a wilderness camp for 23 youth, 15 males and eight females, ages 13 to 18. The presenting issues of the youth were not specified; however, most were reported as working on anger, family issues, impulse control, relationship, and depressive issues,

while psychosis or severe conduct disorders were exclusionary criteria. Youth in both inpatient and outpatient mental health programs participated. Youth and their families attended an initial orientation session in which mental health assessments were given and individual treatment plans formulated, and youth prepared for the camping excursion. Camping and hiking trips, 10- to 13-days long, were staged with youth participating in one of the trips. During the trips, youth participated in group therapy, conducted by licensed counselors. Individual therapy was available as needed, but there was an emphasis on working on issues through the group context. After the youth's participation in the trip, assessments were again conducted. Finally, participants gathered 2 weeks after the end of the camp to process the experience and discuss ways of implementing this experience into their daily lives (Davis-Berman & Berman, 1989).

Compared to before camp, results of inventories indicated that after camp, youth reported higher perceptions of self-efficacy, higher self-esteem, and less behavioral symptoms (Davis-Berman & Berman, 1989). Changes in locus of control were not found to be significant. The results of this study must be considered in light of the fact that there was no control group; however, it appears that when counseling services are included, therapy camps can be effective in enhancing youth self-esteem and perceived self-efficacy, and lessening behavioral issues.

In another study, researchers sought to examine the effects a wilderness therapy camp had on children who were identified as having special needs or were considered at-risk for having special needs, such as coming from a low SES background or having multiple risk factors (Gibbs, More, Frampton, & Watkins, 2008). One-hundred fifty-seven children with a mean age of 8.7 years participated in a residential camp for 4 to 6 weeks. One-hundred of those children's parents also participated in a parenting program, and 57 did not. During weekdays at camp,

children attended an on-site school during the day for 6 hours. Outside of school hours, the children participated in a number of camp-themed activities. Camp counselors worked with children on working together as a group, resolving group conflict through problem solving, primarily through use of CBT techniques, social skills training, and communication training (Gibbs et al., 2008).

Parents and teachers completed measures before and after the children attended the camp. Parents and teachers both reported significant reductions in total behavioral, emotional, conduct, attention, and peer difficulties from before the camp to after the camp for children, both those whose parents participated in the program and those whose parents did not (Gibbs et al., 2008). When examining differences in these scores between children whose parents participated in the program versus those whose parents did not, there were no significant differences, suggesting that parental participation in the program did not have any impact on camp effects (Gibbs et al., 2008). This study suggests that a wilderness therapy camp can have beneficial effects on young children's problematic behaviors, although lack of a control group in this study makes it difficult to state this conclusively.

Neill (2003) summarized the existing meta-analytic research about therapeutic camps. Results from approximately 12,000 participants of all ages were analyzed and Cohen's d effect sizes of .3 to .4, considered medium effects, were found as a result of participation in a therapeutic camp. Areas in which there were the most significant gains among participants included self-control, self-confidence, and self-concept. An interesting finding was that the gains in these areas seemed to increase at follow-up times up to 18 months after completion of camp (Neill, 2003). This suggests that the impact of therapeutic camps tends to be long-lasting;

however, this effect was not found consistently in all meta-analyses, and thus caution must be taken in drawing conclusions about the long-term efficacy of wilderness camps.

In addition, there was a great deal of variability of effect sizes among studies included, which makes general statements about overall efficacy difficult (Neill, 2003). A further limitation is that the reviewed meta-analyses included a number of studies in which comparisons were only made between pre- and post-treatment for the treatment groups without including control groups in the analyses. The lack of a control group minimizes the degree to which the treatment can be said to be accountable for the observed differences, as there may have been other factors accounting for change, such as regression to the mean over time.

In an attempt to conduct a methodologically rigorous summary of camp research, Wilson and Lipsey (2000) conducted a meta-analysis in which studies that were included met the following criteria: they concerned a wilderness camp program that incorporated elements of physical challenge (activities), were group focused, and the programs aimed to improve externalizing behaviors. Participating youth were required to be between ages of 10 and 21. The study also featured control and treatment conditions. Additional criteria were that outcome measures had to be presented in quantitative form and the study had to be published after 1950 (Wilson & Lipsey, 2000).

Based on these criteria, 28 studies, which included 3,000 participants, were included in the analyses (Wilson & Lipsey, 2000). Effect sizes for each study were calculated and all studies were compiled and analyzed. Results indicated that overall Cohen's d effect size for reduction in antisocial behavior and delinquency was .24, a modest, but significant effect. The effect that the type of program and program components had on outcomes was examined. Researchers found

that programs that employed strenuous physical challenges, such as rafting or hiking, and programs that included a therapy component resulted in greater effect sizes (Wilson & Lipsey, 2000).

Rationale for Program Development

As stated previously, youth face a variety of psychosocial issues that have far-reaching ramifications for their development and for society (National Research Council, 2009; HHS, 1999). It is important to intervene on behalf of youth to promote healthy development and for the betterment of society. Behavioral disorders are a common psychosocial issue in children (Sullivan, 2003) and can impact a child's functioning in a variety of ways (Kendall-Taylor & Mikulak, 2009). Therefore, interventions which address child behavioral disorders can help a large number of children and impact those children profoundly.

As summarized in the literature review above, an intervention which has been found to be effective in addressing behavioral issues in children, and other psychosocial issues, is PCIT (Hood & Eyberg, 2003; Timmer, Urquiza, Zebell, & McGrath, 2005). It has been deemed an evidence-based treatment for reducing child behavior disorders (Child Physical and Sexual Abuse Guidelines, 2004). Training child caretakers, such as teachers, residential staff, parents, and foster parents, in PCIT techniques has been shown to be effective in reducing child disruptive behaviors (Diamond, 2010; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Merret & Wheldall, 1993).

Another type of intervention, wilderness therapy camps, have been shown to provide mental health benefits for youth attending them, including gains in self-esteem, interpersonal

skills, and cooperation (Marsh, 1999; Wilson & Lipsey, 2000). However, improvements in youth behavioral issues would be desirable in conjunction with these other improvements. In addition, there have not been any documented efficacious methods of training wilderness therapy camp staff workers to manage camper behavioral issues, possibly a contributing factor in the occurrence of incidents of staff member misconduct, as was cited by researchers from the General Accountability Office in a statement to the United States House of Representatives (Committee of Education & Labor, 2007), leading to calls from leaders in the wilderness therapy camping community to improve training (Crisip, 1998; Davis-Berman & Berman, 1994). Thus it stands to reason that training wilderness therapy camp staff in PCIT-based techniques, with modifications suited to wilderness therapy camps, can help reduce childhood disruptive behaviors and have other benefits as well.

One way training wilderness therapy camp staff in PCIT techniques can have a beneficial impact is that it can likely lead to reductions in staff member stress and staff burnout, a feeling of emotional exhaustion, depersonalization, and lack of personal accomplishment, of which stress is a component (Maslach & Jackson, 1981). Wilderness camp staff, as with many professionals working with children with special needs, experience higher than normal levels of stress at work, which can lead to feelings of burnout (Kirby, 2006). PCIT has been shown to reduce parental stress levels of parents with children with behavioral issues (Hutchinson, 2006; Timmer, Urquiza, Zebell, & McGrath, 2005). Therefore it seems likely that wilderness therapy camp staff would also likely experience reductions in stress levels from utilizing PCIT. As stated previously, stress is also a component of burnout. Correlations have been found between staff burnout and intent to turnover (Wallace, 2011).

Beyond reducing stress, staff burnout tends to be reduced when staff members feel as if they are gaining skills and feel committed to their organization (Wallace, 2011). These feelings could likely be fostered by teaching staff members EBTs, such as PCIT. Taken together, it seems likely that PCIT will help reduce staff members' stress levels, as has been proven with other caretakers; this will likely lead to reductions in staff burnout. In addition, PCIT can help alleviate staff burnout by fostering a sense of accomplishment in staff members and demonstrating the organization's commitment to staff training. In addition, many wilderness therapy camp staff members work at the camps after graduating from college, and then go on to work in other mental health settings (Kirby, 2006). Training staff in EBTs, such as PCIT, imparts skills that they can utilize in future settings, thus benefitting children they serve in these settings.

Another benefit to training staff in PCIT is that there would likely be reductions in camper maltreatment. Child abuse has been found to be correlated with heightened parent stress levels (Scannapieco & Connel-Carrick, 2004; Sullivan, 2003). PCIT has been found to be effective in reducing instances of child maltreatment by parents (Chaffin et al., 2004). A number of instances of wilderness therapy staff members maltreating campers have been documented (Committee of Education & Labor, 2007). Giving staff members the skills they need to manage disruptive camper behaviors can give them alternatives to attempting to address behavior through physical discipline. It seems likely that training wilderness therapy camp staff can be helpful in reducing instances of staff maltreatment.

A final way that training staff in PCIT techniques may prove beneficial is that youth may benefit from the specialized services provided by wilderness therapy camps that they would not

likely receive at a traditional camp. In addition, youth and families who would not otherwise partake of mental health services due to stigma associated with these services or other difficulties initiating treatment may be more likely to participate in a wilderness therapy camp due to the perceived acceptability of youth attending camp. As was stated previously, targeting youth early in the course of the development of psychosocial difficulties and targeting populations who would not otherwise receive treatments has been identified as being a goal of the community of health providers, and is considered to be effective in reducing social costs of mental health difficulties (Institute of Medicine, 1994).

There may be other treatments which are effective in reducing caregiver stress and reducing instances of child maltreatment, and have other benefits in which staff may be trained. However, PCIT seems particularly well-suited for training staff for the following reasons. First, PCIT is an EBT for treating childhood behavioral disorders (The California Evidence-Based Clearinghouse, 2006). This indicates that PCIT has been found to be efficacious in the treatment of childhood behavioral disorders in several randomized control treatments. The label EBT is considered the gold standard in the vetting of efficacious treatments. Second, PCIT utilizes a number of training methods that have been found to be optimal for training staff (Herschell et al., 2010). It incorporates didactic training, utilizes manuals, and coaches participants in vivo. These training methods can all be used for training wilderness therapy camp staff.

Third, PCIT is adaptable based on the needs of the setting and the available resources (Eyberg, 2006). For example, researchers have incorporated an additional phase in the treatment of specific mental health issues (Pinkus, Eyberg, & Choate, 2005). Therefore, it seems likely that camp staff could be trained to address a specific issue germane to the youth attending their

camp. The exact issue that would be addressed would depend on the needs of the specific camp, such as if a camp had a particular difficulty in a certain area or with certain issues that campers had, such as anxiety in going on an overnight trip. However, the framework for how to address these specific issues could be incorporated into a manual for training camp staff.

Fourth, PCIT has been found to be useful with a number of diverse populations (McCabe et al., 2005) and in various settings (Ware et al., 2008); therefore it seems applicable for use with a diverse array of staff members and children in a variety of camps. Finally, PCIT is designed to enhance the relationship between caretaker and child (Eyberg, 1988). Developing relationships and fostering cooperation between staff members and youth has been a goal of wilderness therapy camps since their inception (Beker, 1991).

For these above stated reasons, it seems that training wilderness therapy camp staff in PCIT would yield benefits for youth, staff members, and society. Such a training program is currently not available. This dissertation proposal proposes the development of such a program.

Chapter 3: Needs Assessment

The literature reviewed in the previous chapter illustrated the needs for a training program for wilderness therapy staff. The literature review also suggested an impact model, as outlined in the Rationale section. This chapter focuses on the opinions of key stakeholders and experts regarding the need for such a program, the potentially effective components of the program, and potential barriers of such a program.

Informants

This researcher sought to inform the program development through feedback from key informants. To help ensure that the feedback most fully informed the program, this researcher tried to be "theoretically sensitive" (Glaser & Strauss, 1969). Theoretical sensitivity is an approach in which the researcher, while informed by his or her own views, still tries to fully incorporate data. One way in which a researcher tries to be theoretically sensitive is by theoretically sampling (Glaser & Strauss, 1969). In theoretical sampling, a researcher is strategic about choosing the participants from whom he gathers information. The researcher attempts to gather information from a group of informants who are varied, but who still have "theoretical purpose and relevance" (Glaser & Strauss, 1969).

Five key informants were interviewed regarding the proposed training program for wilderness therapy camp staff. The informants provided feedback about the need for such a

program, the potentially effective components of the program, and potential barriers to such a program. This feedback was incorporated into the program design to improve the program. The key informants were selected for their expertise in one or more of the following realms: mental health treatment program design, training mental health staff, wilderness therapy camps, and PCIT. No single informant was likely to have expertise in all of these areas because no PCIT-based wilderness therapy camp program currently exists. Instead, this researcher sought to recruit individuals with expertise in each of the above desired areas, and in this way, obtained feedback from experts in all aspects of the training program.

Potential key informants were identified by this researcher through his knowledge of individuals with the above-specified attributes (for example, authors of relevant literature) or through referrals by other key informants or experts. To have been considered an expert in one of these areas, the informant had to have a minimum of 5 years working, studying, and contributing in the area of expertise. Potential informants' experience was confirmed early after contact was established with them.

Potential key informants were approached by this researcher via a recruitment letter sent to their email address (see Appendix A). If potential key informants were interested in participating, they indicated their interest via email or a phone call to this researcher. This researcher then made appointments to meet with the key informants individually.

Key Person Interviews

A semi-structured interview (see Appendix D) was used. The questions in the interview were designed to obtain information about how to best accomplish the stated goals and

objectives of the proposed program. The Centers for Disease Control (CDC) Framework for Evaluation of Public Health Programs (1999) served as a guide for generating questions and as a basis for interview topics. This framework was developed by a number of researchers in a variety of public health-related fields as a template for program developers to evaluate their programs. The researchers recommended considering a number of factors when evaluating a (proposed) program, including the aspects of the program to be evaluated, the desired standards for the program, how the program will be evaluated, and how these evaluations would inform the program. Considering these criteria led to the formulation of questions to garner information to assist in developing the program.

In order to obtain the most accurate and insightful information, the questions were modified, rearranged, omitted, or other questions added based on each informant's area of expertise, experience, and responses, and on this researcher's judgment. For example, if the researcher deemed that a follow-up question would help clarify a previous answer or was expected to prove illuminative, then a follow-up question was asked. On the other hand, effort was made to reasonably adhere to the script as it had been devised to elicit important information. In addition, a standardized script helped enable comparisons among different key informants, which enhanced the interpretation of data.

The interview began with questions assessing the informants' views of the needs of the populations targeted by the proposed program. These questions were asked before the program was described, in order to obtain an unbiased assessment of the groups' needs. The proposed program was then described in general outline using a script (see Appendix B), and the key informants were asked questions about the described program. The script was modified based on

the key informants' areas of expertise. For example, if the key informant was an expert in PCIT, the section describing PCIT was omitted and the section describing wilderness therapy camps expanded. This researcher also answered any questions the key informants had about the proposed program.

Procedure

The first steps during the interview were to inform each informant about the nature of confidentiality of the interview and obtain written consent. The nature of informed consent is explained more thoroughly in the following Ethical Assurances section. Next, the interview with the key informant began. This researcher provided an overview of the proposed program. This overview is included in Appendix B. This researcher then asked the informant questions about the proposed program and about the needs of the targeted population.

The interviews were conducted in a quiet room (such as an office or other professional setting), or via Skype or phone call, based on mutual agreement between the key informants and this researcher. The interviews lasted approximately one hour, and were recorded via a digital recording machine. These recordings will be kept as a password-protected file on this researcher's computer. The interviews were transcribed into a written transcript of the interview, which will also be kept password protected on this researcher's computer. Per American Psychological Assocation (APA) guidelines, these data will be retained for 5 years after the completion of this dissertation (American Psychological Association, 2010). At the end of this period of time, the files will be permanently destroyed.

The data collected from the interviews were analyzed for information valuable in developing the training program. This researcher first transcribed all interviews. Then the transcripts were compared by questions to assess the range of opinions on different aspects of the program. The needs of the target population, including the needs for a proposed program, were noted. In addition, key informants' recommendations for training wilderness therapy camp staff to work with campers with behavioral issues were identified. The recommendations and information given by key informants were synthesized with the information gathered in the literature review to determine how PCIT can be adapted to train wilderness therapy camp staff to work with campers with behavioral issues. Findings were taken into consideration when developing the training program. Primary topics of focus when analyzing the key informants' feedback included obstacles to program implementation, perceived strengths and weaknesses of the program, and suggested modifications to the program

Ethical Assurances

All ethical codes of conduct were followed in this study. Participants' rights, as set forth by the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002), were protected at all times. Institutional approval was obtained from The Chicago School of Professional Psychology Internal Review Board (IRB). A proposal for the needs assessment was submitted, and research was conducted in accordance with the approved research protocol.

Informed consent to participate in the study was obtained from all key informants. Informed Consent Forms (see Appendix C) contained the following: the purpose of the study, the

right of participants to decline to participate and the consequences of participating or not, any foreseeable factors or incentives which may influence their participation, any research benefits, limits of confidentiality, and whom to contact for questions about the study. In addition, informed consent for audio recording during the interview was obtained from key informants. The Informed Consent Form was reviewed with the key informants. They signed an agreement with this researcher indicating the informed consent was explained and that they understood and agreed with this information.

Chapter 4: Results of Key Informant Interviews

Demographics

In the following section, the demographics of the key informants will be described. In particular, the criteria that qualified them to be key informants will be detailed. In addition, a de-identified name to refer to the key informants based on distinguishing criteria will be specified. These names will be used to refer to the key informants in the Results section. The key informants are described in no particular order. The demographic information of the key informants is summarized in Table 1.

The first key informant is a professor of social work at a university in the southern United States. She has been involved with wilderness therapy camps for over 15 years, working in a variety of roles, including as a wilderness therapy camp instructor, course director, and clinical social worker. She has published a number of articles and a book on the subject of wilderness and adventure therapy and other experiential therapies. She will be referred to as "the camp researcher."

The second key informant is a professor of clinical psychology at a university in the midwestern United States. She has published a number of articles related to PCIT, and more recently, about adapting PCIT as a teacher-training program. Furthermore, she has over 20 years of experience in researching parenting, parenting evaluation, and parent training. She will be referred to as "the PCIT researcher."

The third key informant is an executive director of a residential camp for children with emotional, behavioral, and learning difficulties. She has been involved in therapeutic camps as a counselor, camp director, and in other roles for over 10 years. As executive director, she oversees the functioning of the residential camp, including the staff training. She will be referred to as "the camp director."

The fourth key informant has been involved with wilderness therapy camps for over 7 years and currently works as a therapist at a community mental health center for children. He has guided wilderness therapy camp expeditions while serving as an administrator. In addition, he has conducted research on the efficacy of wilderness therapy camps. He will be referred to as "the camp leader."

The final key informant has worked as a counselor at a variety of camps for over 7 years. He has worked in camps for children with emotional, behavioral, and learning difficulties, and more recently at camps for children with developmental disorders. He will be referred to as "the camp counselor."

Table 1. Key Informants' Demographic Information

De-identified Name	**Area of Expertise**	**Occupation**	**Years of Experience**	**Additional Information**
Camp Researcher	Wilderness therapy camps	Professor	15 years	Published articles on camp research
PCIT Researcher	PCIT	Professor	20 years	Adapted PCIT
Camp Director	Wilderness therapy camps; staff training	Executive Director	10 years	Trained wilderness therapy camp staff
Camp Leader	Wilderness therapy camp staff	Therapist	7 years	Researched wilderness therapy camps
Camp Counselor	Wilderness therapy camps	Camp counselor	7 years	

Data Processing

The data collected from the interviews with the key informants were analyzed using qualitative data analysis methods, incorporating phenomenological analysis and comparative

analysis. Phenomenological analysis is useful for gathering the impressions of individuals with regard to a particular topic and then systematically analyzing this data to form conclusions (Creswell, 1998). Comparative analysis focuses on generating "conceptual categories" from statements, which are useful for drawing conclusions from the data, and thus inform practice (Glaser & Strauss, 1967). Using this methodological framework, this researcher accomplished the following steps.

First, all interviews were transcribed. Second, the researcher sought to set aside all preconceived notions, in a process called bracketing (Creswell, 1998). Bracketing involves acknowledging that there is personal influence imparted by the researcher when interpreting the data. The researcher does not attempt to ignore these personal biases, but instead acknowledges them and attempts to understand how the biases influence the interpretation. Examples of biases that may have influenced the interpretation of this information included this researcher's own experiences working in camp settings and in staff training. These biases may have influenced the data analysis because this researcher has a proclivity for the methods used in camps for working with youth with behavioral disorders. As a result, it was important for this researcher to guard against an overly optimistic interpretation of camp efficacy. By recognizing these biases, the researcher accounted for them during data analysis. If the researcher denies his or her biases, they might be incorporated into the analysis of data (Creswell, 1998).

However, it should be noted that even though biases might be recognized, they are still present and can influence the interpretation. In fact, it can be viewed that any attempt to analyze data imparts the analyst's subjectivity. Therefore, the data that is reported in this dissertation consists of "second-order concepts," rather than "first-order concepts" (Miles & Huberman,

1994). Second-order concepts are theories which have been interpreted by a party beside the person who originally made the statement.

The third step of data processing entailed gathering all of the data from key informants and then analyzing it by first finding statements in individual transcripts. Statements are units of meaning that the key informant is expressing (Creswell, 1998). For example, several key informants made statements about the uniqueness of camp culture. One informant stated that the uniqueness of camp culture necessitates a trainer who understands this culture and can work within it, as well as a training program which incorporates the culture. The statements were then arranged in groups of similar statements about similar topics or clusters of meaning. For example, this researcher organized similar statements that informants made about the topic of camp culture.

The fourth step entailed comparing these clusters across different key informants, after which themes emerged about various topics. For example, the statement, "The uniqueness of camp culture necessitates a trainer who understands this culture and can work within it, as well as a training program which incorporates the culture," could warrant two different themes, one about training methods and the other about program development. To consider whether this statement is better considered as two different themes or as one theme with two components, this researcher considered the groups of statements of other informants. Because other informants made similar statements about the uniqueness of camp culture, such as that it requires a trainer who can work within that system and also requires a culture-informed training program, it was seen that this was a one theme with two components. This theme was that the camp culture is unique, and two results of that theme are that trainers and the program should adapt.

The themes that emerged were then considered to inform program development. This process can be considered an inductive method (Glaser & Strauss, 1967), in which the information gathered from the participants, as well as from the relevant literature, shaped the program. A concept which is helpful in applying the themes gathered from the informants is "sensitizing concepts" (Blumer, 1954). Sensitizing concepts are themes that the participants intended to make, rather than those which they strictly made, or what could be termed "definitive concepts." Considering the sensitizing concepts within the themes is helpful to be able to construct the program in the manner most true to the meaning that the participants intended to invoke. By constructing the program in accordance with the participants' intended meaning, the program will likely be more helpful to camp staff, as it will be more in accordance with the experiences and advocacy of the experts.

For example, the statement given above, that the camp culture is unique and thus requires a trainer who can work within that system, was represented by an informant who stated that the primitive setting in which the camps occur necessitated that the trainer be prepared to endure those conditions. On the surface level, this statement very clearly was defined to communicate that trainers should be prepared to be in outdoor conditions, where the weather might be extreme or there are many bugs, and where the trainer might feel uncomfortable. On the other hand, there also appears to be a sensitizing concept contained within this statement, that the harsh conditions are a defining quality of camp, conferring benefits to campers who are able to overcome the challenge. Therefore, a trainer should be aware that overcoming adversity is a characteristic of camps of which camp personnel are proud, and which likely permeates through multiple facets of camp. The sensitizing conceptual nature of this comment could be inferred from, among other

statements, the informant's speaking fondly of enduring extreme conditions, himself, when working at a camp. Interpreting this statement as a sensitizing concept then informs the program in that there should be information provided to trainers about being prepared for adversity in a number of ways and building challenging activities into the training. The themes obtained from the analysis are summarized and are presented in the following Results section, organized by theme.

Results

Unique camp culture. The first theme to emerge from the analysis of the interviews with the key informants was that wilderness therapy camps, and camps, in general, tend to have unique cultures within each camp. These cultures consist of unique language, activities, identities, and customs at the camp. Efforts are made to cultivate these cultures to provide campers with an experience of having immersed themselves in a culture separate from the mainstream culture in which they typically reside outside of camp. As stated in the Literature Review, at wilderness therapy camp, this process of separating campers from mainstream culture is done to create a unique environment for the campers and to emphasize the values and skills which campers are expected to absorb. To emphasize the uniqueness of camp, the camp leader stated that the camp culture "is hard to explain because really there's nothing else like it."

Adapting training to meet camp culture. Informants emphasized the importance of integrating any proposed programming, including training, into wilderness therapy camp culture. The camp leader felt that if training did not seem consonant with camp culture, it would likely be

rejected by the staff members who received this training. He felt that training should correspond to camp ideals, including methodologies and practices of working with campers. In addition, the camp leader felt that trainers should be well-prepared to work within the camp setting. He stated that working conditions at camp can be primitive; for example, he cited being outdoors and having limited resources. Therefore, trainers should be aware of this and be prepared to work in this environment. The camp leader felt that ideally, trainers would have experience in this setting previously, perhaps having worked at a camp, so as to fully understand what they would be undertaking in working at the camp.

Emphasizing the importance of training. Informants discussed the importance of engaging camp staff members in training. The camp researcher said that one technique she uses in her training of camp staff members is to begin by having camp staff members share some issues that they are experiencing at camp. This can help staff members to recognize the need for the training and increase their investment in it. The PCIT researcher felt that it was important to listen to teachers' concerns when discussing training and throughout training. She and her research team attempted to address these concerns and incorporate suggestions into the training. In general, informants emphasized the importance of working collaboratively with staff members and explaining the training process to them from the first contact between trainers and staff members.

Building connections. Related to the importance of working collaboratively, informants identified that it would be important to have allies within the camp system to ensure the training

would be incorporated by staff and would continue to be used after trainers left. For example, the PCIT researcher stated that she emphasized this factor when adapting PCIT to be used in classroom settings, in a program called Teacher Child Interaction Training (TCIT). Based on previous research she had conducted and reviewed, she incorporated an emphasis on building connections with school administrators and teachers into her training program. She commented that until she had actually begun the program, she was unsure if the teachers would accept the researchers who were developing the TCIT program there.

Based on early experiences implementing TCIT, the PCIT researcher and her research team trained three professionals to be TCIT trainers at a target school, who would remain at the school to help ensure the school personnel would continue to use the TCIT model. In addition, these professionals developed a group at the school to promote TCIT compliance. The PCIT researcher felt that these trained professionals and the group they created have been responsible for the continued implementation of TCIT at that school. An added benefit of training individuals who would remain within the target system to perpetuate the TCIT model, after initially being a part of that system, was that these individuals understood the culture of their system well and could work within that system, integrating TCIT. In general, informants identified that the prevalence of staff turnover at camps could be considered an obstacle to staff training.

Explaining the purpose of training. There were a number of themes that emerged with regard to the actual training of staff. One theme, in particular, had to do with how much information staff members were given. Two informants felt that explaining the motivation

behind training procedures would help staff members to understand why they were being trained in the way they were. Informants felt that this understanding would help staff members to better adhere to the training procedures and better perform the skills that are being taught. In the words of the camp researcher, "It always helps to understand why you are doing something."

In vivo training. Several informants said that they believed in vivo training would be especially helpful. They said that being able to get feedback while actually performing the techniques that are taught would benefit staff members. The executive director commented that often staff members are "frozen" upon first encountering disruptive camper behavior at the beginning of the camp season, despite having trained for these situations with role plays and didactic means. A number of key informants felt that training in vivo would help new staff members more easily and correctly learn the new techniques for working with campers.

Typical training. Regarding the amount of time that would be necessary for training wilderness therapy camp staff, there was a range of opinions from key informants. The camp director stated that training at her camp first begins with camp administrators, who have had previous camp experience, arriving about 3 weeks before the campers arrive. For the first 12 days, the administrators are trained alone. The administrators are trained to act as supervisors and are trained in the skills necessary to manage counselors, as well as being trained in the skills necessary to manage camper behavior. Ten days before campers arrive, all the camp staff members arrive and are trained for 10 days. All training takes place from 8am until 10pm. The staff members are trained primarily by the administrators on how to use skills to manage camper

behaviors, keep campers involved in activities, and debrief campers after they have had difficulty behaving appropriately.

The camp counselor informant was trained for different lengths of time at different camps. He described being trained for one week before campers arrived at a camp for children with emotional, behavioral, and learning difficulties. During this training, seminars were conducted by lead staff members, among whom were psychologists who trained camp staff. The camp counselor said that he was trained in the rules of the camp, how to work with children with special needs, and how to de-escalate campers when they became aggressive.

The camp counselor also described being trained for one day at a 10-day long camp for children with social communication disorders. This training consisted of seminars and process groups. A primary focus of the training was building relationships with campers. According to the camp counselor, this amount of training was too short, and it was necessary for him to utilize skills he had learned elsewhere to work effectively with the children. Informants uniformly agreed that as many staff members as possible should be trained in methods for working with campers with disruptive behaviors, particularly those staff members having contact with the campers.

These insights from key informants, taken together with the findings presented in the literature review on the variety of camps and training, illustrate that camps are diverse in their focus and training. Training lengths differed from a minimum of one day to a maximum of three weeks for senior camp staff. In addition, the breadth of the training was varied, with focuses on developing different skills at different camp settings. Thus, it seems that training which is designed to help counselors work with behavioral issues that campers display and help them

build relationships with campers should allow for a flexible schedule. This will allow for additional training in other areas in which counselors need to be trained, such as conducting activities or ensuring camper safety, areas that are not covered in Counselor-Camper Interaction Training (CCIT), the training program that was created by the researcher for the purposes of the current study.

Needs of youth and obstacles to success. Disruptive behavior can often preclude youth from having a successful camp experience at a traditional non-therapeutic camp. Youth with these disruptive behaviors would typically create frustrations for counselors and other campers in traditional camps, resulting in interpersonal difficulties and potentially unsafe circumstances in camps unequipped to handle the disruptive behavior. The camp director stated, "The campers at (our) camp have often not been successful at other camps or in traditional schools." Therefore, her therapeutic camp meets a need that cannot be served by non-traditional camps. The camp researcher remarked that while there are some existing therapy camps for campers with disruptive behavior, there are still no uniform training procedures that can be successful in different settings.

With regard to the needs of youth, key informants commented that youth with behavior problems need structure and opportunities to reflect on their behavior. The camp leader expressed that often youth are reprimanded for negative behavior, but do not gain an understanding of why they are acting that way or learn internal controls. Informants commented that in service of the needs of youth, the training of counselors and staff members is being increasingly adjusted so that staff members can work with the behavior problems. For example,

the camp researcher stated that now more often camp staff are processing negative behavior with youth and helping them to understand it.

Counselor training needs. Informants were queried about the current training needs of wilderness therapy camp staff. The camp researcher remarked that there is increasing recognition in the wilderness therapy camp industry of the need for improved training procedures. She said that there have been some programs which have demonstrated effective training procedures, and cited one camp program that used a behavioral modification system to work with campers with attention issues.

The camp director remarked that the training programs at the camp which she directs are sufficient to address the needs of the campers. It should be noted that this training period at this camp is comparatively long, lasting 10 days for counselors and 3 weeks for administrators. However, the camp director also felt that many counselors still exhibited hesitation when working with campers with behavioral issues initially after training.

Other informants remarked that they wished their training experiences at camp had been more exhaustive and that they wished they had feedback in their work with campers. The camp counselor stated that often he and many other staff members would learn through trial-and-error. He asserted that more direct feedback would better prepare staff members for working with camper behavioral issues.

Group management. Informants also commented on the importance of managing the group at camp. For example, the camp counselor stated that there was a balance between

individual needs and the needs of the group. In other words, counselors must decide how much disruptive behavior from a camper can be tolerated before it impedes on the group's ability to participate in camp. The camp counselor felt that having a group behavioral management strategy would be helpful to address disruptive behavior while still focusing on the group. By having a behavioral management strategy, counselors could work with individuals who were having trouble, while at the same time attending to the group. The camp leader expressed that there was a need for staff members to "be trained to work together."

Building camper and counselor relationships. Another theme to emerge was that incorporating relational training is important. In other words, it would be important to train counselors on how to develop effective relationships with the campers. Informants commented that this was important for several reasons. First, having a good relationship with the campers increases the counselor's ability to work effectively with the campers. Campers are more likely to care about doing what they are asked when they are being asked by someone with whom they have a connection.

Secondly, the relationship itself is therapeutic. Many campers attend camps in general for the relationships that they will develop there. For individuals who have had difficult relationships in the past, this may be an especially important benefit of camp. However, forming relationships with these campers can be difficult for counselors to do. Disruptive camper behavior can impede developing a relationship with a counselor due to the counselor having to frequently address this disruptive behavior. Therefore, having training in this area would be beneficial to counselors and campers.

Informants' reactions to CCIT. The outline of the proposed CCIT program was described to key informants, and their opinions of the program and reactions were gathered. In general, informants were supportive of the plan and said they were excited about efforts made to enhance staff training. In addition, informants said that one of the aspects that appealed to them most about the proposed program was that there would be in vivo coaching. Informants felt that this would be an effective way for camp staff members to learn how to work with campers with behavioral issues. They felt that describing the procedures for working with campers was helpful, but that being able to get feedback while working with campers would help staff members to feel more comfortable because there would be a trainer available to help them learn skills. In addition, informants felt the counselors would be able to apply the skills more effectively. The amount of training was also seen to be reasonable, and it was consistent with the amount of training at other camps of which informants were aware. In general, informants felt this was a program in which they could participate.

Coaching in realistic situations. A question some informants had was about the type of activity within which the coaching sessions would be conducted. Informants felt that coaching during actual activities would be superior to coaching in contrived scenarios. Informants felt that counselors being coached in real situations would enhance the generalizability of the skills learned because these would be situations counselors would likely encounter at camp. The camp researcher said, "The more applied (to realistic situations) the training can be, the better." However, informants felt that coaching during "sessions" away from activities could be effective as well.

Trainer feedback to staff members. Several informants commented about trainers giving staff members feedback. Several of the informants had questions about how this would be accomplished. When informants considered that the staff members could be given feedback by trainers talking quietly to them in front of campers, some informants commented that this might be intrusive and hinder the counselors' ability to work with the campers. In addition, the executive director commented that this could potentially undermine staff members' authority. The PCIT researcher stated that when she and her research team had adapted PCIT for teachers previously, they had initially given feedback to teachers live or wrote feedback down to be given to teachers at a later time when it couldn't be communicated to teachers in the moment. The PCIT researcher said that later they began asking the teachers to wear an ear piece through which the trainers could give the teachers feedback, without the students being aware of the feedback being given. The PCIT researcher said that although data about the effectiveness of training using this procedure is still forthcoming, her initial impressions were that this method of giving feedback was superior to giving feedback in person.

Trainer presence at camp. Related to the concern of how the trainers will be giving feedback was how the presence of the trainer would affect the camp dynamics overall. The camp leader questioned how the trainer's presence would be explained, and stressed he felt that this person could potentially interrupt the camp dynamic. The camp counselor stipulated that feedback from the trainer would likely be accepted by the counselors if they didn't "take offense to the feedback or instruction." However, he felt the likelihood of them taking offense would be lessened if "the parameters of the program were very clearly explained." The camp leader

explained that because the dynamic of campers and counselors being separated from mainstream culture serves to create a bond, an outsider could disrupt this process.

Age appropriateness. Another concern expressed by informants was whether PCIT-based techniques would be appropriate for the age level of the campers targeted. In particular, the PCIT researcher questioned whether certain types of skills, particularly the reflection skills used in PCIT, in which the parent being coached is to repeat certain phrases the child uses, would be appropriate for children older than 8-years-old. In addition, the camp researcher felt that using a time-out procedure was not as effective as initially structuring highly organized activities and processing with campers when they were unable to participate in them. Similarly, the camp researcher felt that processing with campers after times they had difficulty behaving appropriately would be an important part of any behavioral strategy.

Summary. In summary of the information gathered from the key informants, first, it was stressed that camp cultures are unique by design and that any proposed training should ideally attempt to incorporate the camp culture to be implemented successfully. Also, camp trainers should be prepared to experience primitive camp conditions during their time training at camp. As a technique to get staff members invested in the training, it can be helpful at the beginning of the training to elicit staff members' feedback about what they would like to get from the training. Trainers can further increase the likelihood that staff will begin to use and continue to use the training by identifying key stakeholders in the training setting, who can be responsible for maintaining the training model.

With regard to the training itself, informants commented that explaining the rationale of training procedures throughout training to staff and involving them in the training through their participation in activities can be effective in helping them to remain motivated to participate in training. Informants also commented that the in vivo training seemed as if it could prepare staff members to encounter actual camper behavior and help them to respond more effectively. The length of training time that informants had experienced or been familiar with at camps was notable for its variability in length, breadth, and material covered. Topics that key informants felt would be important to cover in training included training in group management and in relational skills with campers. Key informants felt that both of these skills would be important in helping to manage camper behavior.

In reaction to the proposed CCIT program, informants were generally positive, noting that the in vivo training seemed especially promising. Issues with the proposed program that informants noted were questions about how the feedback would occur and in what setting, how the presence of the trainer would impact the camp dynamics, and whether PCIT techniques would be appropriate for the targeted age range of the campers. The information and feedback obtained from key informants, as well as the literature review, will inform the development of the proposed CCIT program. The incorporation of the key informants' feedback into the program and the proposed program itself will be described in general in the next section, Program Development.

Chapter 5: Program Development

Need for CCIT

In this section, a program for training wilderness therapy camp staff using PCIT based techniques will be described. This program will be based on the literature reviewed in Chapter 2 and on the results of the key informant interviews. To date, no such program has been developed. To begin, the goals and objectives of the program will be described. Then, the intended participants, including both campers and staff members will be described. Next, the qualifications for trainers will be delineated. Finally, the program components will be outlined here with the full program manual attached as Appendix F.

Counselor-Camper Interaction Training (CCIT)

Purpose. The purpose of the CCIT program is to:

1. Help behaviorally disordered children improve their social and psychological functioning and thus reduce personal and societal cost associated with unmet mental health needs in children;

2. Help disseminate and encourage the use of EBTs;

3. Develop and document an effective training program for training wilderness therapy camp staff;

4. Benefit society from the therapeutic gains of children who attend wilderness therapy camps with staff trained in CCIT. There are a number of benefits expected for children attending camp and having therapeutic interactions with staff members who are able to manage disruptive behavior (Wilson & Lipsey, 2002). There is a great cost to society for unmet youths' mental health needs, particularly behavioral disorders. More healthily

functioning children will likely lead to less need for future mental health services, a reduction in social costs, such as crime, and increases in productivity, which can result from healthy children receiving more education and obtaining more productive employment.

Goals. The goals of the CCIT program are:

1. Children attending wilderness therapy camps will benefit from staff members using CCIT techniques. Their behavior and their relationships with camp staff members will improve, post-staff training in CCIT.

2. There will be reductions in incidents of camp staff maltreatment of children in wilderness therapy camps, post-staff training in CCIT. PCIT has been shown to be effective in reducing incidents of maltreatment of children by parents (Herschell & McNeil, 2005) and has been shown to reduce parental stress, a trigger for child maltreatment (Hutchinson, 2006). These benefits will likely extend to staff members trained in CCIT, which is based, in part, on PCIT. It is expected that wilderness therapy camp staff members will learn effective skills for working with youth with behavioral disorders.

3. Staff members will be able to utilize the skills they have learned in CCIT in settings beyond camp. Many staff members work at wilderness therapy camps to gain experience working with youth with behavioral issues. These staff members may then pursue further education or seek employment elsewhere, working with this population of youth (Fuentes & Burns, 2002). The skills that they have learned from working at the camp are skills that they can take with them as they go on with their work. By learning evidence-based techniques, wilderness therapy camp staff members will likely continue to use these efficacious techniques in the future. In addition, through the spread of these techniques into other settings, there may likely be a contagion effect in which these techniques become widespread in their new setting through social learning.

Objectives. The objectives of the CCIT program are:

1. Staff members will increase their use of the CCIT techniques from pre-training to post-training, as measured by observation of their use of the techniques in natural settings during camp, using the CCIT DCICS Coding Form (See Appendix G within CCIT Manual).

2. Among campers who are paired with counselors who have completed CCIT training compared with a control group, there will be decreases in their disruptive behaviors from pre-training to post-training. The decrease in behaviors will be assessed by measures of

the incidence of disruptive behaviors in natural settings, using the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001).

3. Among campers who are paired with counselors who have completed CCIT training compared with a control group, there will be increases in their compliance with staff directions from pre-training to post-training. The compliance with staff directions will be assessed with the CCIT DCICS Coding Form in natural settings.

4. Among campers who are paired with counselors who have completed CCIT training compared with a control group, they will better be able to participate in camp programming from pre-camp to post-camp. The amount of time and number of activities in which campers engage will be measured with the Camper Off-task Behavior Chart (Appendix A within CCIT Manual).

Target Population

PCIT has been evaluated and found efficacious for children between the ages of 3 and 12 (Chaffin et al., 2004). Although the techniques employed in PCIT would likely not be detrimental to youth outside of those ages, they may be less effective and would need to be modified to be age appropriate. According to researchers who surveyed a number of existing wilderness therapy camps, the age range of youth that are served by these camps is 6 to 26. Combining these two age ranges, CCIT will be intended for children between the ages of 6 and 12.

In terms of presenting issues and youth characteristics, PCIT has been used and found effective with a variety of populations, including youth with behavior issues, attention issues, developmental delays, emotional disorders, and unspecified issues. PCIT has been adapted for use with a number of populations varying by ethnicity, socio-economic status (SES), gender, medical conditions, and neurological impairments; as of yet its use has not found to be contraindicated for any specific populations (Zisser & Eyberg, 2010). The principles proposed

in CCIT are sound, and there is no indication that they would be harmful to any individual children.

In terms of the staff participants, it is somewhat less clear who should be included because PCIT has not been used with camp staff as of yet. However, PCIT's use with similar populations can be extrapolated so that a reasonable estimate of staff members who can successfully use CCIT can be generated. PCIT has been used with therapists, parents, teachers, and residential staff members of various ethnicities, SES, genders, and other demographic factors. Typical exclusion criteria in PCIT studies are the presence of psychotic disorders, mental retardation, active substance abuse disorders, or a history of having sexually abused others. These same exclusion criteria would apply as conditions of employment at a wilderness therapy camp, and thus any staff member who has been vetted through the camp hiring process would be considered fit to be trained in CCIT.

Trainer Requirements

Trainers in CCIT will be those meeting the criteria established in the PCIT training manual for becoming a PCIT master trainer. The first requirement is that these trainers are PCIT therapists. The training requirements for this are: (a) 40 hours or more of individual training in PCIT skills by a PCIT trainer; (b) successful completion of 2 PCIT cases with supervision by a PCIT trainer, who provides feedback; and (c) additional training in advanced PCIT skills and demonstration of mastery.

CCIT trainers must also complete requirements to be an in-agency PCIT trainer. These requirements are: (a) successful completion of at least 4 PCIT cases with

consultation/supervision with a master PCIT trainer for at least 1 year; and (b) having conducted one supervision or training PCIT case under the supervision of a master trainer. Additionally, to become a master trainer able to provide PCIT training at outside agencies, the following criteria must be met: (a) regularly provides advanced training in PCIT; and (b) has knowledge of recent advances in PCIT and able to convey PCIT fidelity across agencies. A master trainer meeting these criteria will train wilderness therapy camp staff in CCIT. Two trainers will be ideal for CCIT. If two trainers are available, one should be a master trainer, while the other may only be a PCIT trainer.

Program Components

In this section, the ways the Literature Review and key informant interviews shaped the program are discussed. The features which are modified from PCIT and the way in which they are modified are also discussed. A brief outline of the CCIT program structure is then provided (see Appendix F).

During the key informant interviews, informants raised several issues they had with the proposed CCIT programming. These issues are addressed here in order to use key informant feedback to shape the program. One objection that an informant raised was that the age range targeted for CCIT may not be compatible with PCIT-based techniques, which are designed primarily for younger children. In response, though PCIT has been primarily developed for pre-school age children, research has shown it to be effective with children up to 12 years of age (Chaffin et al., 2004), though there is some indication that techniques may benefit from being modified somewhat (McNeil & Hembree-Kigin, 2010). Some of the proposed modifications

include using language that is typically more advanced than in PCIT for younger children, requiring less frequent verbalizations from parents, and using more developmentally advanced toys, among other recommendations. These recommendations will be incorporated into the program so that the program can be useful for staff members working with the targeted age range of children.

Concerns which were raised about the presence of the trainer possibly being intrusive to the camp, via giving feedback or even his presence alone, should also be addressed. First of all, CCIT will emphasize that trainers should work to develop a collaborative relationship with the camp from the moment of first contact. Trainers should work to incorporate camp culture in the training and CCIT program. Trainers should also introduce themselves to the campers and explain their role at the camp as being advisers to the camp counselors, while at the same time emphasizing that counselors are the primary authorities at camp.

While giving feedback, trainers should try to remain as unobtrusive as possible. In order to do so, and based on the feedback obtained from key informants, ideally trainers will give feedback to counselors via a microphone and ear piece that the counselors will wear. This will allow for trainers to communicate with counselors in the most unobtrusive manner possible. If this arrangement is not possible and trainers have to give feedback directly to the counselor, they should be mindful not to undermine the counselor's authority and to support the counselor. This can be done by giving feedback quietly, being positive in the feedback given, and communicating via written notes at times.

In response to the concerns about using time-out, it may be helpful to consider alternative viewpoints about whether or not to use a time-out procedure. Both the camp director and camp

counselor described using a time-out procedure at their camps, and the PCIT researcher described using a modified time-out system with teachers in the TCIT system. The time-out procedures these individuals described were short-term and designed to help the child regain control to rejoin the activity. Also, informants identified that processing with the camper after the time-out was important and helpful. As using a time-out procedure is a part of the PCIT disciplinary procedure, it will be adopted in CCIT, though in a somewhat modified manner, allowing for the above concerns to be addressed. The modified procedure is described in the manual.

Differences between CCIT and PCIT

CCIT and PCIT differ in several ways, including the structure of the program, the logistics of when and how the training is conducted, incorporation of group management techniques, and the incorporation of an additional phase of training. In terms of program structure, traditional PCIT normally progresses as parents meet mastery goals for each phase of treatment. In CCIT, training will progress along a fixed course. The structure will consist of: an initial day of CCIT introduction and training in camper-directed intervention (CDI) methods, as is described in the CCIT manual. This will then be followed by two days of in vivo coaching with campers. Then there will be a day of counselor-directed intervention (CODI) training, followed by an additional two days of in-vivo coaching. Finally, an additional phase can be added which can address the camp's unique needs. The purpose of this additional phase and the manner by which it is created is described in the CCIT manual. This would require an additional day of training and an additional day of in vivo coaching.

The total number of days of the program would ideally consist of 8 days, with 5 of those days consisting of training with campers. The shortened length of training compared to traditional PCIT reflects that it is expected that staff members will learn the PCIT techniques in a shorter amount of time compared with parents, because staff members are likely more motivated to learn the techniques due to their desire to work at camp and gain experience with the target population of campers. In addition, counselors have pre-existing skills and education, they are being compensated for training, and there is an expectation that they will learn the skills; the entire camp milieu will also learn the skills, thusly enhancing learning through social learning. The shortened length of time is expected to enable CCIT training to be completed at the majority of camps, even those with minimal session lengths. A previous intervention, TCIT, also has a similar time frame and yielded good results.

PCIT and CCIT also differ in terms of how training is scheduled. Training will be conducted on consecutive days for CCIT, as compared with PCIT or TCIT, both of which are typically conducted weekly. The daily structure is designed to facilitate rapid learning of PCIT skills. The drawback is that there is less time for homework between sessions; however, staff members will still have an opportunity to practice homework daily. This is not wholly atypical, as during some PCIT treatments, when visitation between parents and children is limited due to court mandates, parents may only practice homework one or two times between sessions as well. The structure of the CCIT training could also be condensed, so that CCIT could be conducted over two days as well. If this were the case, daily sessions would be conducted hourly.

Another difference between CCIT and PCIT is that CCIT training will occur in a group format in natural activities. While PCIT is typically conducted with individual parent-child

dyads, CCIT will be conducted with groups of counselors during training. The reason for this is to maximize trainer efficiency and utilize counselors for role-plays to practice skills. During coaching and coding sessions, other counselors and children will be present. Some coding sessions will be conducted during the course of typical activities if the activity provides the opportunity for one counselor to engage for some time individually with at least one camper, and during CDI, provides the freedom for the camper to guide play. This may occur during a relatively unstructured activity, such as free play or arts and crafts, or may occur by pulling a counselor and camper or campers aside and conducting an individualized opportunity for counselors to practice skills. A coaching session is expected to last 20 minutes.

Another variation between CCIT and PCIT is the incorporation of group management techniques. Because counselors, with other co-counselors, are responsible for the management of a group of campers, it is important to include techniques for working with a group of youth. This has been done with adaptations of PCIT in schools and residential facilities. Adaptations of techniques for working with a group included revising expectations regarding certain verbal statements by teachers or staff members. It is not reasonable to expect staff members to avoid all commands or questions when working with a group of children, so there was allowance for some of these verbal behaviors, but with the goal of reducing them. The use of selective attention in the group was another adaptation. Staff can manage groups of youth by using CCIT techniques with a group, such as by focusing on youth behaving appropriately. In addition, a goal and reward system, in which campers can earn rewards for achieving behavioral goals, was found to be helpful in managing group dynamics and will also be incorporated into CCIT.

Finally, CCIT will incorporate an additional phase of training. In a past study, researchers incorporated an additional phase of PCIT to meet the specific needs of the target population. This was shown to be effective in helping parents incorporate PCIT techniques to address a specific issue. This can also be done in CCIT. During the initial consultation, trainers will consult with administrators to address issues specific to their staff members' needs. This may include incorporating a phase to address a specific youth issue, such as when PCIT was adapted to address anxiety issues. It might also be a phase that addresses a particular problematic scenario at camp, such as at the waterfront or during an overnight trip. The key to developing this additional phase will be to incorporate CCIT techniques, which are used with individual campers, for use with the group and to utilize multiple counselors to manage the group of campers.

Structure of CCIT

An emphasis of CCIT is on effectively implementing the program in camp cultures that may be relatively unfamiliar with the programs and methods used in the program. One way to do so, which is outlined in the CCIT manual, is to develop collaborative relationships with camp staff members. The manual describes how to initiate contact with camp staff members, elicit their input as to what they desire from training, describe the training, and to work collaboratively to address issues that may impede implementation of the program. A benefit of CCIT is that there is flexibility in the training program to accommodate the needs of a camp in terms of time, focus, and structure of the training, among other factors. Personalizing the program and

developing strong relationships with camp staff members can help with the implementation of the program and its successful integration into the camp culture.

Training of camp staff will take place over three phases. The first phase, CDI or camper-directed intervention, is similar to the child-directed intervention (CDI) phase in PCIT. Both programs incorporate the use of techniques called PRIDE skills, which adults use to effectively engage children; this acronym stands for Praise, Reflect, Imitate, Describe, and show Enthusiasm (Hembree-Kigin & McNeil, 2010). In both programs, there are sessions during which the trainer or therapist instructs the adult in the use of these skills and then coaches them in subsequent sessions. Differences are that in CCIT, there is a shorter amount of time for training, the skills are taught through active instruction (similar to the focus on experiential learning at camps), and the coaching is done in actual camp activities.

During the CDI phase, as in PCIT, staff will be taught the PRIDE skills. The purpose of this phase is to build the relationship between staff member and the camper. Staff members use these skills to help create a rewarding experience for campers during sessions in which they play with the campers. Staff members are taught to ignore off-task behaviors that are tolerable. Campers are more likely to listen to staff members and play appropriately after experiencing staff members using the PRIDE skills. The CDI phase in CCIT will last three sessions, each lasting approximately 2 hours per unit, consisting of five camp staff members. In the first session, staff members will receive direct instruction in the use of the skills and practice in role plays. The next two sessions will consist of staff members practicing these skills with campers and receiving instantaneous feedback from trainers. Staff members will also complete homework assignments consisting of practicing the skills.

The next phase of CCIT will be the counselor-directed intervention (CODI), similar to PCIT's parent-directed intervention (PDI). Similarities between PCIT's PDI and CCIT's CODI are that in both programs, adults are taught to give effective commands to children and there is a time-out sequence taught for managing child non-compliance, both of which are taught through instruction and coaching in both programs. A difference between the two programs is that in CCIT, the time-out procedure does not involve the adults putting their hands on the children or using a time-out room, but rather using group management and selective attention during child non-compliance. Also, CCIT allows for time for processing behavior with campers, unlike PCIT. A final difference is that there are less CODI sessions and coaching takes place via realistic scenarios. During CODI, staff members will be taught methods for managing disruptive camper behavior. Staff will learn to implement a safe and effective time-out procedure. Staff members will be taught these techniques directly in the first session, and will then practice them with campers with trainer feedback in the next two sessions.

Finally, there will be an additional phase, in which group management techniques utilizing PCIT skills will be emphasized. This phase will also be directed toward a particular problematic area at the camp, similar to additional phases which have been implemented in PCIT to target specific child behaviors in other programs. The focus of this additional phase will be determined through collaboration with camp administrators to address specific areas of difficulty at camp, such as a camp overnight trip or at the waterfront. The program manual will guide trainers through determining a specific problem area with administrators, how to determine goals for behavior in this area, how to use PCIT techniques to support campers working towards these goals, how to form contingency plans for encouraging campers to meet these goals, and how to

use group management techniques to work with a number of campers. Staff will be taught these techniques during the first session and will practice these techniques, with feedback, in a second session.

The CCIT program is explained in full detail in the CCIT manual in Appendix F. This manual is designed to provide detailed instructions for implementing the training program from the beginning to the end, providing trainers with all of the information and resources necessary to implement the program. The program is then discussed, and a cost-analysis and a proposal for evaluating the program are presented in the following sections of this dissertation.

Chapter 6: Proposed Program Evaluation

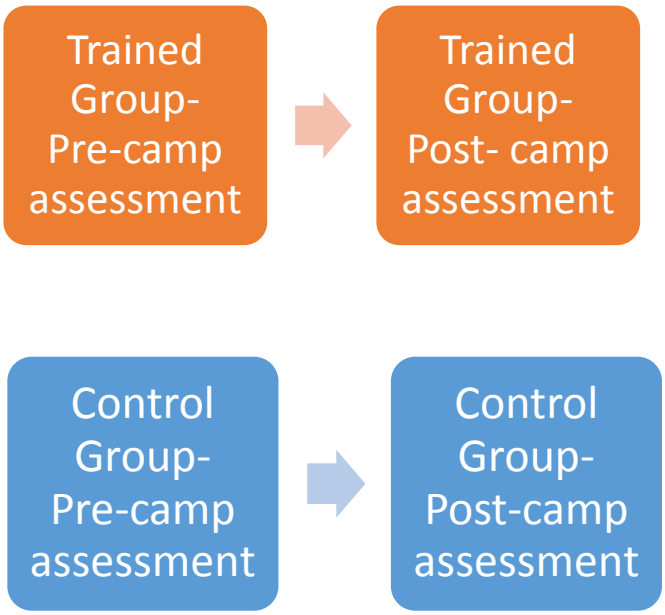
As an initial attempt to evaluate the efficacy of this proposed training program, the program objectives are proposed to be evaluated in the ways described below. The evaluation is designed to be conducted by the CCIT trainers. These trainers must meet qualifications described in the CCIT manual.

First, an overview of the evaluation procedures will help clarify the evaluation design. Generally, the evaluation consists of comparing measured behaviors before and after CCIT training or camp in order to assess the impact of CCIT. As there are a number of benefits conferred upon campers from attending camp, which may lead to improvements in behaviors assessed in this evaluation, it is difficult to discern to what extent the improvements are due to CCIT and to what extent the improvements are due to the campers attending camp. In an attempt to clarify this ambiguity, there will also be an evaluation of campers and counselors who have not participated in CCIT. Changes in behavior found in campers and counselors in this condition will reflect the impact of camp only. Then, these data can be compared with the data collected from the campers and counselors who have received CCIT.

Thus, the design of this evaluation is a quasi-experimental pre-post control group design. The design of this evaluation is somewhat limited by the logistical constraints of the camp schedule. A typical camp schedule might consist of separate sessions for different groups of campers over a summer. Thus, during one session the staff members could be naïve to CCIT,

and in a subsequent session they could be trained in CCIT, allowing for evaluation in both conditions. The quasi-experimental research design is illustrated in the following figure:

Figure 2. Quasi-Experimental Research Design



This design is somewhat limited because it is expected that there would be gains in skills from working at the camp over time, thus resulting in improved skills in the second session. Thus, improvements in the second session, in which CCIT is taught, might reflect improvements due to experience, rather than improvements due to CCIT. Therefore, it would be desirable to evaluate several camps, with some camps receiving CCIT training in the initial session and some camps acting as the no-treatment control during the first session and receiving CCIT training in the second session. The between- and within-camp comparisons will allow for an initial attempt

to separate the practice effect from the treatment effect. This research design is somewhat limited because there will be variability from camp to camp, thus threatening internal and external validity. However, though this design is imperfect, it represents the best design, given the constraints involved in conducting an evaluation within an operating camp.

The first consideration that should be given when conducting the evaluation is whether a particular camp will be a camp that acts first as a control camp, then a treatment camp or whether the camp will be a treatment-only camp. It would be desirable for trainers to be able to randomly assign camps to a specific condition. Once the group assignment has been determined for an individual camp, the trainers should then proceed with the evaluation.

At camps being evaluated as the control condition, trainers should attempt to mimic the evaluation scheme that will be conducted in the CCIT treatment condition. Thus, the timing of the evaluation and the manner in which the evaluation is conducted will be similar to that in the CCIT treatment condition. In the following description of the evaluation procedures, there will be references to the CCIT training. However, if the evaluation is conducted in the control camps condition, the same procedures will apply, but without there being CCIT training. Thus, trainers should consider that there will be an approximate 8-day period of camp between initial assessment, referred to in the evaluation description as the "pre-training assessment," and the final assessment, referred to in the description as the "post-training assessment."

Structure of Evaluation Process

The entire evaluation process will approximately be structured as follows. The overview of the evaluation is provided here, with the specific evaluation procedures detailed in the

following section. One of the evaluation measures consists of obtaining information from the parents of campers at pre- and post-camp. During the initial meeting between trainers and camp administrators, when training is being planned, trainers should discuss with the administrators how they can give provide parents with the parent pre-camp assessment forms (to be discussed in the following section), which will need to be completed before camp. Also to be determined is how they trainers will give the parents the parent post-camp assessment forms they will need to complete at the end of camp. The forms may be mailed to parents or arrangements can be made for parents to complete the forms on-site before the camp and afterward.

The trainers will then be introduced to the campers and counselors, as described in the CCIT manual. There will be a brief introduction where campers and counselors will learn each other's names and discover to which groups the campers are assigned. This information will be necessary for completing thorough observations.

Before the pre-training assessment, training of camp staff for conducting some evaluation procedures (which are described below) will take place. This can be done at the beginning of the day, before the pre-training assessment. During the pre-training assessment, these camp staff members will be conducting observations of activities. Also, during the pre-training assessment, trainers will be meeting with camper and counselor dyads to observe counselor use of targeted behaviors and camper behavior. The procedures for both of these assessments are described below.

After the pre-training assessment is complete (to be described in further detail below), there will be 8 days of CCIT training or an 8-day wait period if the camp is in the control condition. The post-training assessment will be conducted after the 8 days of camp have passed.

During this evaluation, trainers will again evaluate the behavior of the same counselor and camper dyads they previously evaluated. Supervisors will also be evaluating activity periods, to be described in further detail below. The data gathered will then be analyzed using procedures described below.

This forms the general framework for the evaluation. Efforts should be made to adhere to the procedures to help ensure consistency in the evaluation and improve validity of findings. In the following section, the objectives of CCIT and the evaluation procedure for each objective is described.

Evaluation Procedures

Objective 1: Staff members will increase the use of CCIT techniques from pre-program to post-program, as measured by observation of their use of the techniques in natural settings during camp. Staff members' use of CCIT techniques will be assessed by using the CCIT Dyadic Counselor-Child Interaction Coding System (CCIT-DCICS; Appendix G within CCIT Manual). The CCIT-DCICS is based on the Dyadic Parent-Child Interaction Coding System (DPICS), a system for coding an adult's use of PCIT skills with a child (Eyberg, Nelson, Duke, & Boggs, 2005). The DPICS is a well-researched instrument. It has been shown to have generally adequate to strong inter-rater reliability (kappa levels from .38 to 1.00 and .29 to .88 for child and parent assessments of various behaviors, respectively), moderate test-retest reliability (.34 to .57 kappa values for different scenarios), and appropriate validity (Eyberg, 2004).

The CCIT-DCICS is based on the DPICS, but has been adjusted to reflect differing target goals by camper age, with slightly differing criteria for classification of behavior by age, as described in the manual (see Appendices G.1 and G.2 in CCIT Manual). The CCIT-DCICS is also simplified to focus on PRIDE behaviors and behaviors to avoid, called "Don't Behaviors." The CCIT-DCICS also eliminates evaluation of other behaviors such as touch, and assesses use of ignoring. The CCIT-DCICS will be used in training to provide feedback for the counselors who are being trained in CCIT. It will also be used to measure the acquisition of target skills by counselors.

The CCIT-DCICS must be administered by a qualified PCIT therapist, who has been trained in the DPICS coding system. For the purpose of program evaluation, the CCIT-DCICS will be administered before training begins at the pre-training assessment as a baseline reading of staff members' use of CCIT skills with campers. It will also be administered following the completion of training at the post-training assessment. In accordance with DPICS protocol, trainers will guide counselors in administering three scenarios with campers. The scenarios are each 5 minutes long and involve counselors instructing campers to guide the play, allow the counselor to guide the play, and to clean up. Trainers will record the counselor's behavior based on DPICS coding criteria. In addition, during this time camper behavior will also be evaluated, as will be described in Objective 3.

The procedure for determining sufficient sample size of campers to observe is specified below. In order to evaluate a sufficient number of campers for robust analysis, some counselors may participate in coding with different campers more than once. Counselors should only be assessed the first time they participate in a coding session so that duplicate counselors are not

evaluated. Only the campers should be coded the second time a counselor is in a coding session. Counselors should not repeat coding more than twice in an evaluation period to avoid evaluation fatigue. The manner by which counselors and campers are assigned to coding sessions is described below.

The number of targeted behaviors listed on the CCIT-DCICS form will be recorded for each counselor assessed. The targeted behaviors are those outlined in the manual in the PRIDE skills section. The behaviors that are desired are Praise, Reflect, and Describe. While Imitate and Enthusiasm are also desired behaviors and components of the PRIDE behaviors, they are difficult to quantify and thus will not be objectively assessed. This is supported in that Imitate and Enthusiasm are not behaviors to be coded on the DPICS-III Coding Form (Eyberg, McDiarmid, Duke, & Boggs, 2004). In addition, in the DPICS-III Manual there is not psychometric information for behaviors Imitate and Enthusiasm, thus calling to question the reliability and validity of these codes (Eyberg, McDiarmid, Duke, & Boggs, 2004). The behaviors that are to be avoided are Criticizing, Questioning, and Commanding. The number of behaviors in each of those categories will be recorded for each counselor. Each of these behaviors will be analyzed in terms of change from pre- to post-training. An increase in the number of positive behaviors and a decrease in the number of negative behaviors is desired.

Objective 2: Wilderness therapy camp campers' disruptive behaviors will decrease from pre-program to post-program. The Child Behavior Checklist for Ages 6–18 Teacher Report Form (CBCL-TRF 6-18; Achenbach & Rescorla, 2001) is a 118-item inventory completed by teachers about their school-age students, assessing teachers' views of their

children's behavior issues. The CBCL-TRF has been well-researched and has shown good validity and discriminant validity in use with identifying externalizing behavior issues (Hudziak et al., 2004). The CBCL-TRF contains multiple scales, one of which, the Externalizing Behavior Scale, will be used to measure the extent of disruptive behaviors counselors observe in the campers. Specifically, the total score on the Externalizing Behavior Scale will be used.

It will not be possible for counselors to complete the CBCL-TRF before camp begins, as the counselors need to observe the campers' behaviors. However, counselors will complete this measure near the beginning of camp, at the completion of the first phase of CCIT training, camper-directed intervention (CDI), and again after the campers complete camp. The language of the CBCL-TRF will be modified to query counselors about behaviors they have witnessed in the time they have been with the camper or since their previous evaluation. Scores from the first assessment and the second assessment for the treatment and control groups will be compared to assess the impact the CCIT training program has had on camper behavior.

Objective 3: Camper cooperation with staff directions at wilderness therapy camps will increase from pre-program to post-program. In order to assess camper cooperation with staff directions, the DPICS will be used to code campers' responses to staff directions. In accordance with DPICS protocol, trainers will guide counselors in administering three scenarios with campers, as described above. Trainers will observe activities and record the camper's response based on DPICS coding criteria. These detailed criteria provide the basis for judging a camper's response to a counselor's directions as being compliant or non-compliant.

It is somewhat open to judgment as to the number of campers who should be observed. It is desirable to observe a large percentage of a camp's campers to help ensure that a broad spectrum of campers are being represented in the observations. In addition, a sufficient number of campers should be observed to be able to conduct appropriate statistical comparisons of pre- and post-training measures. With these considerations in mind, it seems appropriate to observe at least 20% of the campers at the camp and a minimum of 30 campers at both pre- and post-training times. Trainers should randomly select the campers they will observe during these observations, selecting the minimum number of campers necessary to meet observation number goals. Each camper selected should only be observed one time, so as to avoid biasing the results by weighting a certain camper by repeatedly observing her.

In addition, trainers should also select the staff member with whom the camper will be participating in the scenarios. The staff member selected should be counselors who typically work with the selected campers, for example primary counselors or programming counselors. Staff members should then be randomly assigned to work with a particular camper, with all the staff members being assigned to a camper and some randomly being assigned to more than one camper, if necessary, to meet the minimum number of campers desired. The same camper and staff dyads should be observed both at pre-training and post-training, in order to ensure accurate comparisons.

Trainers should allow 15 minutes for observation of the three 5-minute scenarios, with another 5 minutes of procedural time allocated. Thus, to meet the goal of observing at least 30 campers, there should be 10 hours of observation time at both pre- and post-treatment. Trainers will conduct these observations during observation days before and after the training. Each of

the scenarios will produce a score which reflects the proportion of directions with which campers complied, compared to directions given. These scores at pre-training and post-training for both the control and treatment groups will be compared using paired comparisons.

Objective 4: Campers will increase the amount of time they are participating in camp activities from pre-training to post-training. Campers will be charted for the amount of time in which they are and are not participating in camp activities. In order to record these figures, camp supervisors will be trained by trainers to collect this information. Camp supervisors are usually managerial staff members at the camp, typically in that role because they have advanced skills or experience. These supervisors will be identified by camp administrators before beginning data collection. Supervisors should have flexibility to observe a number of activities, and should not have duties which interfere in their ability to record information during observation days before and after training. Trainers should meet with the identified supervisors to train them in the data collection. The trainers will review the Camper Off-task Behavior Chart (see Appendix A within CCIT Manual) that the supervisors will use to record camper participation.

Supervisor training procedures for observing camper behavior. Trainers should instruct supervisors in the following areas. First, trainers will notify supervisors about which activities they will need to observe on observation days before and after training. Observations will be in 1-hour or one activity period increments. Supervisors should bring the chart with them to the assigned activity. They should complete the information at the top of the form. The supervisors

should not announce to the campers or counselors that they will be observing the activity, so as not to influence camper or counselor behavior.

Supervisors should then record each of the campers' names in the appropriate box and then record any instances in which a camper is not participating in the activity for at least 5 minutes, and the amount of time that the camper did not participate. A camper is considered not participating in the activity if he or she is not doing the same activity that the group is doing. Allowances will be made if reasonable accommodations are made by counselors so that the camper can closely approximate what the group is doing, such as providing a camper who may be overstimulated in a group with space to complete an art project that the group is doing. Examples of not participating include: sitting on a bench, demonstrating disruptive behavior, being in time-out, running from the activity, or leaving the area.

Two supervisors will be assigned to observe the same activity in order to assess the inter-rater reliability. The supervisors should not communicate with each other during observations and should not compare their data. After observing the activity, the supervisor should return the chart to the trainers.

After explaining these directions to the supervisors, trainers should then supervise the supervisors in practicing observing an activity. The supervisors should be instructed to conduct the observation as if it were genuine. In addition, trainers should also observe the activity and complete a Camper Off-task Behavior Chart to assess inter-rater reliability. The goal is for the supervisors to have 95% agreement with the trainer.

Inter-rater reliability will be calculated by summing the times for each camper for which the raters are in agreement and dividing by the total amount of time observed for the campers.

So if the supervisors observe a hypothetical group of two campers for 1 hour and supervisors A and B both record Camper 1 being off task for 5 minutes, and Supervisor A records Camper 2 being off task for 5 minutes, while Supervisor B records Camper 2 being off task for 10 minutes, then the amount of time they are in agreement would be 115 minutes. This figure would be divided by the length of camper time they observed, 120 minutes, resulting in an agreement percent of approximately 95.83%. Discrepancies should be discussed between trainers and supervisors to come to consensus.

This entire observation process, comparison of inter-rater agreement, and discussion should take place two times. The reason for it taking place two times is so that supervisors will have two opportunities to demonstrate proficiency, while not having to allocate an exorbitant amount of time to training. Supervisors who are in agreement more than 95% with trainers for both observation sessions are considered able to observe sessions. Supervisors who have not met 95% agreement will be given one more practice observation period to meet the 95% agreement with the trainers goal. If they meet the goal, then they are considered able to conduct observations. Supervisors who are unable to meet the agreement criteria will not be asked to observe sessions.

Trainers should choose the minimum number of campers to be observed, which should be the same number observed in the CCIT-DCICS coding evaluations, as addressed in the previous evaluation point. Trainers will then randomly choose activities that supervisors will observe and which will ensure observation of the minimum number of campers. Each camper should only be observed once, and only in one activity. It is desirable to sample a wide variety of camp activities that are feasible for supervisors to observe. Trainers should have supervisors observe

the same activities with the same campers and counselors at both pre- and post-training to ensure that differences in campers or counselors are accounted for.

Observation charts of the same activity by two different supervisors will be compared. Charts with 95% agreement will be considered valid. Charts with less than 95% inter-rater agreement will be considered invalid and the data will not be used. The number of invalid charts will be reported.

The percentage of camper on-task behavior will be calculated as the amount of time spent in off-task behavior subtracted from the total time, and then divided by the total time (each rounded to 5 minute increments). This figure will be calculated for each camper. The percentages of on-task camper behavior before and after training for the control and treatment groups will be compared.

Chapter 7: Cost Analysis

This chapter will review the costs associated with implementing CCIT so that an individual attempting to implement this program will be able to anticipate costs associated with it. The costs listed here are estimates. As this program has not yet been implemented, it is difficult to state with a high degree of certainty what the actual costs will be. The estimates for the costs are derived from listing all of the resources and materials involved in implementing CCIT, calculating the initial cost for an item, the time these resources are used, and the cost for each unit of time, as well as an expected final cost amount.

The expected costs for the items are taken from previous research, primarily from research involving PCIT, as well as from research of current prices of items. When alternatives or a range of options are possible regarding specific resources, their costs will be presented so that an agency implementing the program can tailor the costs to its needs. A medium to large size camp, with eight bunks, eight campers to a bunk, and two counselors per bunk, is considered for illustrative purposes. Camps of different sizes can adjust costs accordingly.

The costs for developing a PCIT program have previously been estimated to be $14,000 in start-up costs and $1,000 in costs for therapy for each child (Goldfine, Wagner, Branstetter, & McNeil, 2008). Goldfine, Wagner, Branstetter, and McNeil reviewed previous estimates of PCIT costs. The most significant initial cost was the cost of constructing the PCIT room. The

costs to equip the room were estimated to be approximately $5,000 to $6,000. In CCIT, there will not be a therapy room; thus there will not be a cost to outfit it.

Among the initial costs, only the audio equipment will be necessary for CCIT. The audio equipment will be used by the CCIT trainer to communicate with the counselors during training sessions. Thus, the audio equipment should consist of 2 two-way microphone and earphone sets for the trainer and counselor to wear. Consultation of PCIT literature as to the cost of this item is not applicable, as the audio equipment that is recommended is designed to be used with an in-room microphone, while CCIT audio equipment should consist of the microphone and ear-piece as a self-contained unit. An appropriate technology for this purpose would be a two-way radio with microphone and earpiece. A search of Amazon.com for 2 two-way radios with microphones, earpieces and chargers returned results ranging from $49.99-$92.86, resulting in an average of $71.43.

Another significant cost, borne primarily at the start of a CCIT program, is the training of the CCIT trainer. As specified in the manual, the CCIT trainer should have achieved advanced-level PCIT training. There are likely two paths to obtain the services of an advanced-level PCIT trainer for CCIT. The first path is to train a senior camp counselor or administrator in advanced-level PCIT training. The advantage of this method is that the CCIT trainer would then be familiar with the camp culture and would likely be employed at the camp for a long period of time (given that this person is a senior staff member), and would thus provide an eventual reduced cost to the camp compared with hiring a PCIT-trainer for each camp cycle in which CCIT training is desired. A disadvantage to this method is that it is expensive to provide a counselor with advanced PCIT training and it takes a longer period of time.

This advanced-level training is obtainable through PCIT training facilities. An example is Oklahoma University, at which the cost for obtaining basic PCIT training is $4,000 per participant for a 5-day workshop ("PCIT Training Opportunities, 2014"). Transportation to the workshop, in addition to lodging and other expenses for the participant, are additional costs to consider. It seems reasonable that $100 a day would cover lodging and expenses, and transportation could be arranged from $200-$1,000, depending on the flight origin, within the U.S.

Once basic PCIT certification is obtained, advanced PCIT training costs $4,500, plus trainer expenses, such as lodging, and lasts 2 days. After a trainer has obtained advanced PCIT training, she can become a PCIT within-agency trainer and be able to train others in PCIT. The cost for this is $750.

For agencies that want to make an extended commitment to provide CCIT over several camp cycles, obtaining this type of training for a senior staff member would likely be cost-effective over the long-term. The staff member thus trained would be able to train incoming cohorts of counselors and also train other staff as CCIT trainers. Thus, the total cost to train a senior staff member to become a PCIT trainer is estimated to be: $4,000 (PCIT basic training) + 5x$100/day (expenses) + $600 (average flight cost) + $4,500 (PCIT advanced training) +2x$100/day (expenses) + $600 (average flight cost) + $750 (PCIT trainer training) = $11,150. There would be no additional cost for the staff expenses, as this staff member will already be employed by the camp; thus her salary would be already considered a camp expense. However, there would be an opportunity cost for the staff member who is being trained, as she would not be able to perform her other camp work-related duties while receiving training. Thus, this work

would have to be done at a different time and the cost of the lost work must be estimated. The training consists of a total of 7 days.

The camp director is a position that would likely have the education and skills necessary to receive PCIT training and would be able to make a commitment of time sufficient to justify the training expense. The median salary for a camp director in 2010 was reported to be $52,000 (Jacobs, 2014). To calculate the cost of 7 days of lost time, salary-per-day is first calculated. To calculate median salary per day, let it be considered that there are 365 day in a year, less 14 days of vacation. Workers typically work 5 to 7 days per week. These estimates total around 251 (rounded up) working days. Thus, the median salary per day is estimated to be $207.17 per day ($52,000/251 days). With these figures in mind, a loss of 7 days of work would equate to a cost of $1,450.20.

An alternative to obtaining training for a senior staff member is to arrange for a PCIT trainer to come to the camp to train camp staff in CCIT. The apparent advantage to using this method is that there might be a lower initial cost, as the cost of training would be borne by this trainer. The disadvantage to this method is that there would be an expense to obtain this expert's services each time CCIT training was desired. Contracting with an offsite trainer each time training is desired could work better for camps that provide only periodic staff training. However, it is difficult to determine what the cost of this method would be, as there are not currently practitioners who are PCIT certified and training in CCIT methods. Thus estimates of what a PCIT trainer might charge to provide onsite CCIT training to camp staff are not certain.

There are PCIT trainers who provide in-agency training, where a PCIT trainer will come to a site and train a group of at least seven staff members in PCIT methods, at a cost of $3,500

per person, plus trainer transportation costs. As the minimum cost for this training would be $24,500, it seems that this option would not make economic sense, compared with obtaining advanced training in PCIT for a senior staff member. Thus for purposes of this cost analysis, the option to train a staff member in PCIT will be the only method considered.

As the training of a camp staff member would likely be a significant expense, it would behoove the camp to carefully consider the staff member they would train. The staff member should be able to make a significant commitment to remain at the camp long enough to justify the expenditure of the training of the staff. Efforts to identify staff members who would likely remain at camp for an extended period of time should be made. Also, efforts should be made to retain the PCIT-trained staff members, and the significant investment in the training of the staff member in PCIT should be communicated to other staff. In addition, it may be possible that this staff member will become a PCIT trainer, in which case it would be possible for this individual to then train other staff in CCIT. This would significantly reduce later expenses of having to send staff to training off-site.

A final training cost will be the cost of training the staff in CCIT. It is expected that the training should last about 6.75 hours per counselor (3 x 1.25 hours training/ instruction session + 4 x 30 min. coaching and homework + 1 hour group management coaching = 6.75 hours training/staff). Median weekly wages for counselors were reported to be $235 (Jacobs, 2014). This equates to $235 for 40 hours, or $5.88 per hour. While this is currently less than minimum wage for employees in the United States, there is a minimum wage exception for seasonal camp employees (Section 13[a.3] exemption of the Fair Labor Standards Act [FLSA]). Thus, the 6.75 hours of training will cost about $39.66 per counselor (6.75 x $5.88). Training a camp with

approximately 16 counselors would result in a camp cost of $634.56 (16 x $39.66). However, this training is meant to supplant existing training methods, and thus should not pose an additional cost. In terms of the cost per camper, there is no additional time that is being spent conducting CCIT with campers; thus there should be no additional expense incurred.

Another cost to consider is the cost of the special playtime toys. A basic configuration of special playtime toys, consisting of "a coloring book and markers, Play Doh, Mr. Potato Head, and Legos," costs $50.79 (Goldfine, Wagner, Branstetter, & McNeil, 2008, p. 128). These toys would likely be more appropriate for campers up to age 8. It is likely that more advanced toys would be necessary for campers ages 8 to 12. Thus, the coloring book should be replaced with an activity book and the Mr. Potato Head should be replaced with a model set. The difference in cost for the older set compared to the younger set would be an increase of $20, resulting in an older set of toys costing $70.79. It is likely that a camp will have additional toys that can be used for special playtime as well. However, a configuration of these toys at a minimum should be available for each group of counselors who are being trained in CCIT.

It is likely, as specified in the CCIT manual, that counselors within each group will be alternating in conducting special playtime with campers so that remaining counselors can cover the remaining campers. Thus, a collection of special playtime toys for each group of counselors should be available. The number of collections and type of toys will depend on the number of groups that are being trained and the ages of the campers. Thus for a camp with eight groups of counselors and campers, eight collections of toys should be available. Assuming half of the groups use the toys for younger campers and half the groups use the toys for older campers, the resulting cost is $486.32 (4 x $50.79 + 4 x $70.79).

A final cost for the CCIT program will be miscellaneous costs, such as the cost of photocopying handouts, providing pens and other writing supplies, and any other incidental costs that arise. It is expected that these costs will be less than $50. The total costs for the CCIT program are presented in Table 2.

Table 2. Projected Costs of CCIT Program

Item	Cost (in dollars)
2 Two-way radios	71.43
PCIT trainer training	11,150
Loss of work cost	1,450.20
Counselor training	634.56
Special playtime toys	486.32
Miscellaneous	50
Total	13,842.51

Chapter 8: Discussion

In this dissertation, a program called Counselor-Camper Interaction Training (CCIT) was developed to address a need for effective training of wilderness therapy camp staff in techniques for working with children with behavioral issues. Wilderness therapy camps have been found to be helpful in addressing psychosocial difficulties in youth and in improving their functioning (Hattie, 1997; Neill, 2003; Wilson & Lipsey, 2000). However, to date, there has been a lack of training programs that have demonstrated efficacy for training wilderness therapy camp staff in working with children with behavioral issues (for a review, see Gillis & Gass, 2003; Scott & Duerson, 2010).

Evidence-based treatments (EBTs) are treatments that have demonstrated efficacy in treating a particular intended issue. There has been an increased focus in the mental health community on promoting the use of EBTs (for a review, see Herschell, Kolko, Baumann, & Davis, 2010). PCIT is an EBT that has been found effective in reducing behavioral issues in children (for a review, see Thomas & Zimmer-Gembeck, 2007), in reducing caretaker stress (Hutchinson, 2006; Timmer, Urquiza, Zebell, & McGrath, 2005), and in reducing incidence of child maltreatment by caretakers (Chaffin et al., 2004). These issues for which PCIT has been found effective are issues which are salient for counselors working with campers with behavioral issues. Thus, it stands to reason that PCIT-based techniques taught through in-situ coaching can be effective in addressing many of the training needs of wilderness therapy camps. Wilderness

therapy camps with well-trained counselors can engage children as an early-intervention treatment, sustain youth in treatment, and provide a treatment with reduced stigma.

A strength of CCIT is that it is based on programs, wilderness therapy camps and PCIT, which, as stated above, have been found to be efficacious in their own respects. In addition, both of these treatments have sound theoretical bases, which were reviewed in the Literature Review (Berman & Davis-Berman, 1995; Brinkmeyer & Eyberg, 2006). PCIT has been validated for use with diverse groups (Eyberg, 2005) in terms of family relationships (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005), intellectual functioning (Bagner & Eyberg, 2007), ethnicity (Butler & Eyberg, 2006), types of disordered behavior (Pincus et al., 2005), and setting in which it is conducted (Lyon & Budd, 2010), among other factors. Thus, PCIT is effective in a variety of conditions.

The versatility of PCIT makes it ideal for training wilderness therapy camp staff. Wilderness therapy camps have been found to be diverse in terms of their scope, size, setting, activities offered, and staff characteristics (Fuentes & Burns, 2002). Thus it appears that PCIT-based interventions would be well-suited to be adapted to meet the needs of counselors in a multitude of settings.

Another strength of CCIT is that it is relatively non-intrusive and is designed to maximize camper participation in camp programming. Several of the key informants in this dissertation commented on the importance of a camp's culture to be able to flourish. PCIT itself is designed to foster relationships between the child and the caretaker, which in itself is a goal of camps (Russell, 2001). It is also designed to promote joint engagement in activities between the child and caretaker (Eyberg, 1988), another goal of camps (Russell, 2001). In addition, CCIT allows

the camp to incorporate an intervention consistent with the camp philosophy. For example, after not following directions and taking a time-out, the counselor may talk to the camper about how the camper was not embodying values that the camp promotes, such as teamwork.

One way in which CCIT has been modified from PCIT, and which can be considered a strength of CCIT, is that CCIT contains instruction in using group management techniques. The group management techniques in CCIT are similar to techniques for managing behavior in individual work with campers. Thus, the group management module helps counselors to be able to apply the skills they learn for individual work to working in a group, a situation that they predominantly encounter in their work with the campers. The techniques that are taught in this module should be familiar and a natural extension from counselors' individual work, allowing for ease of learning. In addition, the methods taught in this module allow for those campers making good choices to remain engaged in camp programming, while minimizing the negative impact on the group by the camper who is making bad choices. Counselors are also guided in applying CCIT to a particular area of camp that may be difficult. Learning how to target specific areas of camp is a skill that will be helpful to counselors throughout their work at camp.

CCIT furthers the in vivo training that is used in PCIT. In a review of different training methods' impact on skill acquisition, a combination of live role plays, presentation of training materials in different forms, and in vivo coaching was found to be superior than any of the methods separately (Herschell et al., 2010). In particular, in vivo training in which participants can receive live feedback was found to be especially helpful. In addition, several key informants remarked that they viewed receiving live feedback as the most valuable type of training they had

experienced, and recommended its use in any training program. This type of live coaching is done in PCIT.

CCIT furthers this live coaching by creating situations typical to camp for the counselors to practice skills with the campers, as well as having trainers coaching during actual activities at camp. These scenarios provide the most realistic opportunities for counselors to practice the target skills with campers. The realistic nature likely increases the generalizability of skills so that counselors will be able to easily use these skills in natural settings with campers.

Another strength of CCIT is that the CCIT manual is quite detailed to help ensure consistency in training and correct teaching of the CCIT techniques. There is also a focus on learning through engaging in activities, a type of learning that is considered a tenet of camp philosophy. The activities are designed to help counselors learn CCIT skills, engage with each other, and to align with camp culture.

An aspect of CCIT that may be considered a weakness is that CCIT is fairly intensive in terms of the demand of money, time, and effort involved in training. As discussed in the Cost Analysis, CCIT is expensive, especially to initiate the program. Camps typically are limited in terms of budget, and implementing CCIT would likely require a significant portion of that budget.

In addition, CCIT requires a significant amount of time for training. The training is designed to be conducted over eight modules. These modules likely would take place over 8 days, but this schedule could be somewhat flexible. This amount of training is within the range of training that key informants identified as typical of the amount of training that is at camp, however it is still a significant amount of time.

CCIT also requires a great deal of effort. Training requires active engagement by counselors, and there is homework required for nearly every module. As with PCIT, the completion of homework and active involvement in training is critical for its success. As such, a focus of the CCIT manual is on engaging camp personnel in training. This effort will likely lead to greater investment in training and will yield greater results.

Another weakness of CCIT is that it has not yet been implemented or evaluated. While efforts have been made to base the program on sound principles and techniques that have been found to be effective for similar populations in different settings, the only way to evaluate the program's efficacy is through implementing the program at camps and evaluating the results. To this end, there is a proposal for evaluating the program included in this dissertation. The goals and objectives for the program are specified and measures have been identified for evaluating these outcomes. After evaluation of the program, CCIT's efficacy should be revisited and discussed.

The methodology employed to collect data from participants was grounded in phenomenological research. An advantage to this method, as compared to quantitative methods, is that more nuanced information was obtained than could be obtained from a forced choice survey, for example. The questions were open-ended questions, which allowed the respondents to respond however they wanted. In addition, because the interview was semi-structured, it was possible to change the questions or ask follow-up questions as needed to obtain further information.

There were limitations to this methodology, as well. A qualitative methodology was used to analyze interviews done with key informants. Though the methods used in creating the

surveys, obtaining the information from the informants, and analyzing the information were grounded in qualitative theory, the methods used were imperfect. First of all, there are necessarily limitations in what can be asked of informants, thus there were biases introduced by this researcher in selecting the questions asked.

Related to the influence of the researcher developing questions, there is also personal bias introduced by this researcher in terms of the way the information was analyzed. As was discussed in the methodology, attempts were made to bracket preconceived notions so that they would not influence the interpretation of the information. However, as this process involves subjective interpretation by the researcher, personal bias cannot be avoided.

The sample size, the number of key informants, was also relatively small. Because of this, there are limitations on the generalizability of the findings to the camp community at large. Querying these professionals was for the purpose of obtaining insight into what experts in the fields of PCIT, wilderness therapy camps, and staff training viewed as necessary components of a training program. However, due to the small sample size, it is likely that the views of the key informants do not represent the views of the entire camp community. Furthermore, extensive information about the key informants was not obtained. This also limits generalizability of findings, as it is not possible to consider the extent to which the key informants' characteristics represented the camp community at large.

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Appendix A: Key Informant Letter

The following script will be sent via email to the identified participants to request their participation as key informants:

Dear (key informant),

My name is Brian Syzdek. I am a graduate student at The Chicago School of Professional Psychology. I am currently conducting research for my dissertation. My dissertation topic is about adapting parent-child interaction therapy (PCIT) to train wilderness therapy camp staff. I am creating a program manual that will use methods used in PCIT that have been adapted to train staff and teachers in other programs, and applying them to train wilderness therapy camp staff. Based on information gained through my literature review, I believe there is a need for this type of program and it has the potential to be an effective program. I thought that based on your experience, you would be able to provide me with valuable feedback about the proposed program to assist in its development.

I am requesting that you serve as a key informant for my dissertation on this program development. As a key informant, you would meet with me and participate in an interview about the topic. The interview would consist of first, an informed consent. Then I would ask you some questions regarding needs. Second, I would describe the proposed program in general outline to you. Third, I would ask you questions about the proposed program. It is expected that the entire interview will last approximately one hour.

If you are willing to participate in this interview, please contact me via email at bms5919@ego.thechicagoschool.edu or by phone at 312-402-2271. Please let me know if you have any questions about this process or about my dissertation. I appreciate your consideration of my request.

Sincerely,

Brian Syzdek

The Chicago School of Professional Psychology

Appendix B: CCIT Description

(To be read to key informants unfamiliar with PCIT.) Parent-child interaction therapy (PCIT) is an evidence-based treatment to help reduce childhood disruptive behavior disorders and the occurrence of child maltreatment. Parents in PCIT learn techniques for working with their children and building relationships. PCIT consists of a child-directed intervention phase (CDI), in which parents learn appropriate ways to play with their children and communicate. This is followed by a parent-directed intervention phase (PDI), which teaches parents specific behavioral management techniques to effectively discipline their children. PCIT has been found to be effective with a variety of populations and is currently being adapted for use in a variety of settings beyond the traditional clinic context.

(To be read to key informants unfamiliar with wilderness therapy camps.) Another way to address problematic child issues is with wilderness therapy camps. Wilderness therapy camps are camps for youth, and are intended to increase biopsychosocial wellness in an outdoor setting. However, current wilderness therapy camps lack systematic training for staff that has been deemed efficacious. Current training programs used at camps often have been inadequate in teaching staff proper techniques for working with youth with special needs, illustrating the importance for standardized training methods to be adapted in training wilderness therapy camp staff.

For this dissertation, I propose to develop a training program for wilderness therapy camp staff utilizing PCIT techniques and teaching methods, called Counselor-Camper Interaction Training (CCIT). CCIT is different from PCIT in the following ways. First, the structure of CCIT will be different than PCIT. Normally in PCIT, parents must meet mastery goals in one phase to move to the next phase. In CCIT, training will proceed at a fixed schedule due to limitations in time and resources. CCIT will be completed in eight modules. These modules may be spaced out at daily intervals or may be completed in groups, lasting at least 2 days.

Second, this time frame is also different than PCIT, which is typically conducted weekly. Third, CCIT will be conducted in a group format. This is similar to group PCIT, an adaptation of PCIT that has been recently manualized. CCIT will be conducted in groups to maximize training efficiency. Fourth, CCIT will include training in group management techniques, a skill important for wilderness therapy camp staff, who are typically responsible for several campers. Staff will learn to use PCIT based techniques with multiple children to manage behavior. Related to this, some of the behaviors typically targeted in PCIT, such as elimination of all questions or commands verbalized by the parents, will be tolerated in camp staff in CCIT, as it is unreasonable to eliminate all of these behaviors in the camp setting.

Fifth, an additional phase of training will be incorporated into CCIT which will incorporate a level system for addressing a particularly difficult camp issue, as identified by camp administration, and teach staff group behavioral management techniques using PCIT skills. Training in this phase will combine PCIT techniques and a level system to target the specific issue identified by administrators and trainers. Sixth, because CCIT will be conducted in a natural setting, not in the PCIT therapy room, equipment, such as the one-way mirror and

earpiece to communicate trainer feedback, will not be available and modification in feedback procedures will be required. In CCIT, feedback will be given directly or in written form.

Training of camp staff will take place over three phases. The first phase, CDI or camper-directed intervention, is similar to the child-directed intervention (CDI) phase in PCIT. During this phase staff will be taught the PRIDE skills, which stand for Praise, Reflect, Imitate, Describe, and show Enthusiasm. The purpose of this phase is to build the relationship between staff and the camper. Staff members use these skills to help create a rewarding experience for campers during sessions in which they play with the campers. Staff members are taught to ignore off-task behaviors that are tolerable. Campers are more likely to listen to staff and play appropriately after experiencing staff using the PRIDE skills.

The CDI phase in CCIT will last three sessions. In the first session, staff will receive direct instruction in the use of the skills and practice these skills in role plays. The next two sessions will consist of staff practicing these skills with campers and receiving feedback from trainers. Staff members will also complete homework assignments consisting of practicing the skills.

The next phase of CCIT will be the counselor-directed intervention (CODI), similar to PCIT's parent-directed intervention (PDI). During this phase, staff will be taught methods for managing disruptive camper behavior. Staff will learn to implement a safe and effective time-out procedure. Staff will be taught these techniques directly in the first session and then practice them with campers with trainer feedback in the next two sessions.

Finally, there will be an additional phase, similar to additional phases which have been implemented in PCIT in other programs, to target specific camp issues. This phase will combine

PCIT techniques with a level system to address an aspect of camp that children may find particularly challenging. In addition, staff will be taught group behavioral management techniques for working with a group of campers with several staff. The focus of this additional phase will be determined through collaboration with camp administrators to address specific areas of difficulty at camp, such as a camp overnight trip or at the waterfront. Staff will be taught techniques based in PCIT methods to help guide campers through the targeted activity during the first session, and will practice these techniques with a level system, with feedback, in a second session. This phase will be role-played and then counselors will perform this phase with campers with trainers giving feedback.

In total, it is anticipated that there will be eight sessions of CCIT training. The sessions are intended to be taught on consecutive days to maximize trainer efficiency and allow staff to practice the techniques. However, sessions can be modified to be over a shorter period of time, such as two days, if needed.

Thank you for considering this proposed training program. I will now ask you some questions about this proposed program.

Appendix C: Informed Consent

Informed Consent

Title: *Adapting PCIT to Train Wilderness Therapy Camp Staff*

Investigator: *Brian Syzdek*

I am asking you to participate in a research study. Please take your time to read the information below and feel free to ask any questions before signing this document.

Purpose: *My dissertation topic is about adapting parent-child interaction therapy (PCIT) to train wilderness therapy camp staff. I am creating a program manual that will use methods used in PCIT, that have been adapted to train staff and teachers in other programs, and applying them to train wilderness therapy camp staff.*

Procedures: *I am requesting that you serve as a key informant for my program development dissertation. As a key informant, you would participate in an interview about my dissertation topic. We will first review the components of informed consent. Then I will ask you some questions regarding needs of children and therapeutic camps. Second, I will describe the proposed program in general outline to you. Third, I will ask you about your thoughts about the proposed program. It is expected that the entire interview will last approximately one hour. The entire interview will be digitally recorded and later transcribed.*

Risks to Participation: *It is not anticipated that there will be any serious risks to participation. The interview will consist of a conversation with questions and answers, typical of an academic dialogue. The questions are focused on the topic of PCIT, wilderness therapy camps, and staff training. You may volunteer to supply information about your own experiences with these subjects. There may be some mild discomfort or stress when asked questions requiring thoughtful answers, but this is not expected to exceed the demand typically required in an academic dialogue.*

Benefits to Participants: *You will not directly benefit from this study. However, I hope the information learned from this study may benefit society in our understanding of how*

to best treat children with special needs, especially behavior issues, and how to best train wilderness therapy camp staff to work with these children and others. There will not be any immediate compensation/remuneration, but I will offer to share my dissertation findings with you upon completion of the dissertation.

Alternatives to Participation: *Participation in this study is voluntary. You may withdraw from study participation at any time without any penalty.*

Confidentiality: *Your identity and the information gathered in our interview will be kept confidential. This information will only be seen by me. The digital recording and transcript will be kept password protected on my computer for 5 years after publication of my dissertation, per APA guidelines. After that time, the recording and interview will be destroyed.*

Questions/Concerns: *If you have questions concerning your rights in this research study you may contact the Institutional Review Board (IRB), which is concerned with the protection of subjects in research project. You may reach the IRB office Monday-Friday by calling 312.467.2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654.*

Consent

Subject

The research project and the procedures have been explained to me. I agree to participate in this study. My participation is voluntary and I do not have to sign this form if I do not want to be part of this research project. I will receive a copy of this consent form for my records.

Signature of Subject: _____
Date: _____

Signature of the Person Obtaining Consent: _____
Date: _____

Appendix D: Semi-Structured Interview

1. What do you think are the greatest needs for youth, particularly those with behavioral issues? (If the mental health needs of youth are not addressed in the answer, the following question will be asked.) What do you think are the greatest mental health needs for youth, particularly those with behavioral issues? Are these needs being adequately met with current programs or resources? If no, why not? What obstacles exist to meeting these needs?

2. Are existing wilderness therapy camps currently meeting the needs of children with behavioral issues? Why or why not?

3. Are there obstacles/issues that are currently preventing these children from having a successful camp experience? What are they? Are there obstacles/issues that prevent children from being involved in camp programming? What are they?

4. Please describe the types of emotional/behavioral issues these children exhibit that might prevent them from having a successful camp experience.

5. What do you think is needed at wilderness therapy camps in order for youth with behavioral issues to be able to participate in these camps? Is there a need for specialized camps for children (ages 6-12) with behavioral disorders? Is yes, what would such camps look like? Please explain/describe your experience. What major issues exist at wilderness therapy camps? Would a program which targeted such issues be beneficial? Why or why not? What specific aspects of a program would be helpful?

6. What are current methods for managing emotional/behavioral issues at camp? How successful are these methods?

7. How well are staff currently meeting the emotional/behavioral needs of the children in the camps?

8. What do you think is needed for wilderness therapy camp staff working with children with behavioral issues to be able to work with these children effectively? What knowledge, skills, and/or behavior do staff members need to meet the needs of the children in camp? Do the staff members currently have these skills, behaviors, and knowledge? How important is it for staff to have these skills, behaviors, and knowledge?

9. How are staff members in wilderness therapy camps currently being trained?

10. What staff training needs are currently unmet?

11. What components must a staff training program contain to ensure that it will be implemented and successful in a therapy camp setting?

12. What issues should be considered in developing such a staff training program?

13. Should all staff members be trained? If not, who should be trained and why?

Here an overview of the proposed program will be described, using the script contained in Appendix B, and the following questions will then be asked to the key informants to obtain their perception of the program.

1. What are your initial impressions of this program?

2. What are the program's strengths/weaknesses?

3. What modifications do you think are necessary to make this an effective program?

4. How helpful will this program be in improving staff members' skills, behaviors, and knowledge? How helpful will this program be in improving other unmet staff training needs?

5. How effective will this program be in addressing campers' obstacles/issues?

6. How well could this program be implemented?

7. How intrusive will this program be to other camp programming?

8. What staff should be trained in this program?

9. What other things should be added to this program and what should be removed or modified?

10. How do you feel about the amount of training?

11. What could be done to increase the "buy-in" or investment in participating in this program by camp staff?

12. (For informants with camp administrative experience) If you were a camp administrator how likely would you be to implement this program? What would increase the chance that you would implement the program?

13. (For informants with PCIT experience) Do you anticipate that camp staff trained in this program would be able to learn and effectively use the PCIT skills? What would help them to learn these skills in this program? Do you feel the length of training is sufficient for camp staff to be trained in the skills?

14. What obstacles to implementation do you anticipate?

Thank you for participating in this interview. Your feedback is valuable in developing this program designed to help children and staff involved in wilderness therapy programs.

Appendix E: Camper Off-Task Behavior Chart

Supervisor's name:

Time and Date:

Activity period:

Co-supervisor observing:

Camper Name	Type of Off-task behavior	Amount of time (Rounded to 5 minutes)	Percent of on-task behavior (length of activity-amount of time off-task)/length of activity	Amount of time in agreement with co-supervisor

A. Sum of amount of time in agreement with co-supervisor for all campers:

_____

B. Total amount of camper time observed (umber of campers observed x Length of time observed:_____

C. Percent in agreement (Blank A/ Blank B from above): _____

D. At least 95% agreement? Yes/No; If "Yes" ratings can be used

Appendix F: CCIT Manual

Table of Contents Page Number

Manual Overview

Introduction

This manual will describe the program Counselor-Camper Interaction Training (CCIT), a training program for wilderness therapy camp staff based, in part, on parent-child interaction therapy (PCIT). The program is based on a thorough review of the literature on PCIT and wilderness therapy camp training, as well as interviews with experts in these fields. This information is reviewed in a published dissertation (Syzdek, 2014). The manual is designed so that the entire training program is able to be implemented by qualified trainers (qualifications specified below), in collaboration with camp administrators or other parties interested in training wilderness therapy camp staff. As of this manual's writing, the efficacy of CCIT has not yet been determined. Proposed evaluation procedures can be found at the end of this manual. Parties interested in evaluating this program are encouraged to contact the above author at the email address specified below.

Purpose

The purposes of the CCIT program are as follows:

1. Help behaviorally disordered children improve their social and psychological functioning, and thus reduce personal and societal costs associated with unmet mental health needs in children.
2. Help disseminate and encourage the use of Evidence Based Treatments (EBTs).

Goals

The goals of the CCIT program are as follows:

1. Children attending wilderness therapy camps will benefit from staff using CCIT techniques. Their behavior and their relationships with camp staff will improve, post-staff training in CCIT.
2. There will be reductions in incidents of camp staff maltreatment of children in wilderness therapy camps, post-staff training in CCIT.

Objectives

The objectives of the CCIT program are as follows:

1. Staff will increase their use of the CCIT techniques from pre-training to post-training, as measured by observation of their use of the techniques in natural settings during camp, using the modified CCIT-DCICS Coding Form (Appendices G.1 and G.2).
2. Among campers who are paired with counselors who have completed CCIT training (as compared with a control group), there will be decreases in their disruptive behaviors from pre-training to post-training. The decrease in behaviors will be assessed by measures of the incidence of disruptive behaviors in natural settings, using the Child Behavioral Checklist 6-18 (CBCL 6-18, Achenbach & Rescorla, 2001).
3. Among campers who are paired with counselors who have completed CCIT training (as compared with a control group), there will be increases in their compliance with staff directions from pre-training to post-training. The compliance with staff directions will be

assessed with the CCIT-DCICS Coding Form (Appendices G.1 and G.2) in natural settings.

4. Campers who are paired with counselors who have completed CCIT training (as compared with a control group) will better be able to participate in camp programming from pre-camp to post-camp. The amount of time and number of activities in which campers engage will be measured with the Camper Off-task Behavior Chart (Appendix A).

Target Population

Children. CCIT is intended for children between the ages of 6 and 12. It is based on techniques, primarily from PCIT, found efficacious for children within that age range. Researchers evaluating PCIT efficacy have recommended slight adjustments to the techniques for children ages 8-12 (Chaffin, 2004; McNeil & Hembree-Kigin, 2010). Therefore, this manual will incorporate those modifications for campers ages 8-12, which will be indicated in sections titled, "For Counselors Working with Campers 8-years-old and Older."

CCIT is intended to be used with a variety of populations, including youth with behavior issues, attention issues, developmental delays, emotional disorders, and unspecified issues. It is not anticipated to be contraindicated for any specific populations. The principles espoused within CCIT are sound and there is no indication that they would be harmful to any individual children.

Modifications might be necessary for CCIT to be effectively implemented with populations varying by ethnicity, socio-economic status (SES), gender, medical conditions, and

neurological impairments, among other factors. This manual identifies core features of CCIT that should be retained, but there is flexibility in adjusting the program as needed. Furthermore, CCIT is designed to help camp counselors interact with campers optimally and address camper behavior. Additional camp procedures for addressing camper issues may be implemented in addition to CCIT and camp staff can be trained in additional therapeutic methods. Procedures which do not interfere with CCIT training or its use during camp are allowable.

Staff. In terms of the staff participants, it is possible to train all camp staff in CCIT. In fact, training all staff in CCIT may enhance its effect, as staff will be using consistent language and methods with campers. This may help campers to adapt more quickly to the camp structure. Campers who are familiar with the camp structure because staff members are using consistent language and methods with them, such as using a consistent time-out procedure, will be familiar with the expectations of staff and the consequences of their behavior. As a result, it is expected that campers will respond to directions more quickly, which will help them more fully participate in camp programming.

It is not anticipated that there would be any factors that would limit camp staff in participating in CCIT. Exclusion criteria would be the presence of psychotic disorders, mental retardation, active substance abuse disorders, or a history of having sexually abused others. Any exclusion criteria that would prohibit staff from participating in CCIT would likely prohibit them from being employed at a wilderness therapy camp. Therefore, any staff member who has been vetted through the camp hiring process would be considered fit to be trained in CCIT techniques.

Trainer Requirements

Trainers in CCIT will be those meeting the criteria established in the PCIT training manual for becoming a PCIT master trainer. The first requirement is that these trainers are PCIT therapists. The training requirements for this are:

1. 40 hours or more of individual training in PCIT skills by a PCIT trainer;

2. Successful completion of 2 PCIT cases with supervision by a PCIT trainer, who provides feedback;

3. Additional training in advanced PCIT skills and demonstration of mastery.

Additionally, CCIT trainers must also complete requirements to be an in-agency PCIT trainer. These requirements are:

1. Successful completion of at least 4 PCIT cases with consultation/supervision with a master PCIT trainer for at least 1 year;

2. Conduct one supervision or training PCIT case under the supervision of a master trainer.

Additionally, to become a master trainer able to provide PCIT training at outside agencies the following criteria must be met:

1. Regularly provides advanced training in PCIT;

2. Has knowledge of recent advances in PCIT and able to convey PCIT fidelity across agencies.

A master trainer meeting these criteria will train wilderness therapy camp staff in CCIT. One trainer is sufficient for training in CCIT. However, additional trainers may train camp staff

if desired, sharing in the training responsibilities. If more than two trainers are used, one should be a master trainer, while the other may only be a PCIT trainer.

Structure

The structure of the manual can be discerned from the table of contents. In the initial introduction section, an overview of the training program is provided, including the goals and objectives of the program, the target population, the requirements for its implementation, as well as the overall program structure and the structure of individual sessions. The manual then describes the pre-training preparation, including initial contact between camp administrators and camp trainers and how to plan for the implementation of the program. The next section of the manual then describes the staff training.

Training is divided into three phases. The first phase, camper-directed intervention (CDI) is focused on building the relationship between camp staff and the campers. During this phase, counselors are taught skills for engaging campers and encouraging positive behaviors while they play. Counselors are coached in the utilization of these skills by trainers. During the next phase, counselor-directed intervention (CODI), counselors are taught effective ways to discipline campers. Counselors again are coached in the administration of discipline procedures. The final phase is targeted towards a specific issue at camp, identified collaboratively by trainers and camp administrators. In addition, counselors are taught group management techniques, based on CCIT methods. The last section of this manual contains a suggested evaluation plan reproduced from the author's dissertation. Finally, the appendices of this manual contain all the handouts to be used in the training, so they may be copied from this manual.

The entire course of training is expected to last eight sessions. The length of sessions will vary based on the number of counselors in each group. It is expected that the three instruction sessions will last about 1½ hours, for a group of about six to eight counselors and the coaching sessions should last about 20 minutes per counselor. The sessions can be scheduled over 2 to 8 days, depending on camp needs. If trainings are scheduled for less than 8 days, then multiple sessions per day will be scheduled, with homework conducted between sessions.

The training should be administered in sequential order, without skipping any sections. The entire manual should be read before training is attempted. Only professionals with the training specified in the Trainer Requirements section should implement this training. Trainers should adhere closely to the procedures described in the manual. However, as this training program is designed to be implemented in a variety of settings, slight adjustments may be required to effectively implement the training. Trainers should ultimately use their own clinical judgment if implementing a described procedure is problematic. Any questions about the training can be directed to this manual's author, Brian Syzdek, at bms5919@ego.thechicagoschool.edu.

Structure of the Sessions

The sessions in this manual are described from pre-session preparation through the end of the session and the assigning of homework. Having already read the manual through completely, trainers are further encouraged to review each session's protocol before beginning each session to ensure full preparation. In addition, it would likely be helpful for trainers to have this manual

with them throughout training, including during sessions, so that they may refer to it for information, if necessary.

The sessions are organized as follows:

1.) Session Objectives - In this section, the objectives of the session are specified. It is expected that these objectives will be achieved by the end of the session. Trainers are encouraged to review these objectives to ensure they are met at the end of the session.

2.) Session Outline - An outline of each session is provided as a way to orient trainers to each session and guide them through the protocol of the session.

3.) Session Materials - A list of the materials necessary for the session is provided. Trainers should ensure these materials are prepared and are brought to the session.

4.) Session Protocol - This is the lengthiest part of each session, in which the session's protocol is explained. The procedures are generally described in steps which trainers should follow. The procedures are designed to be specific so that trainers are able to implement the training in a manner consistent with the manual. Because CCIT is based on efficacious practices found in PCIT, it is important to follow this training procedure closely.

5.) Homework - In most sessions, trainers will assign homework to the counselors. This section describes the homework to be assigned.

Materials

The following materials are necessary for CCIT:

- CCIT manual.

- Handouts located in CCIT manual appendices and sufficient copies for camp staff.
- A set of 2 earpieces and microphones with a two-way radio. This is similar to the equipment used in PCIT. However, while PCIT radios are typically embedded within the therapy room, these radios should be portable to allow for use in the field. The equipment will used by the trainer to communicate with the counselors during in vivo or in situ coaching. It may be possible to communicate without this equipment, but it is recommended that this equipment be used.
- Pen and paper for note-taking.

For a full accounting of the cost of implementing this program, including the cost of this equipment, see the dissertation by Syzdek (2014).

Suggested Evaluation

Overview of Evaluation

This training program is designed to be evaluated so that its efficacy can be determined. A proposed evaluation is described in full in the dissertation (Syzdek, 2014). Anyone interested in evaluating the program is encouraged to refer to the dissertation for a description of the proposed evaluation.

Session Descriptions

Pre-Training Preparation

Session Objectives

- Trainers and administrators will meet and familiarize themselves with the goals of the program.
- Trainers and administrators will work together to mold the CCIT training experience to meet the needs of the particular camp.
- Trainers and administrators will develop a good relationship and partnership for implementing CCIT.

Session Outline

1. Trainers will contact camp administrators or camp administrators will contact trainers.
2. A planning session will take place.

Session Materials

1. CCIT manual;
2. Materials for taking notes.

Session Protocol and Explanation

It will be important to address issues of program implementation, beginning with initial contact between camp staff and trainers. Good first impressions and sensitive initial

communication can help ensure smooth program implementation. CCIT will be a new training experience, and as is often the case when new training or procedures are introduced, these changes may be difficult for staff to fully accept and incorporate. However, if initial proceedings are handled with sensitivity toward the difficulty of these transitions and efforts are made to accommodate the needs of staff, the likelihood of successfully adopting the training program increases.

Much of the theory guiding the initial implementation of the training program is based on the research of Gershenson, Lyon, and Budd (2010), who described implementing PCIT as a school-wide teacher training program. In their article, the researchers described in detail efforts that were made to engage school personnel in the implementation of the training program and the success due to these efforts. These researchers emphasized the importance of planning for the implementation of training in early sessions. Drawing from this research, much of the preparation for future sessions occurs in this session.

Therefore, a good deal of description of the objectives for CCIT is provided in this Session Protocol and Explanation. This is so that the trainer can fully understand the purpose for the subsequent session objectives and how these objectives can be achieved. By understanding these factors, the trainer can guide this planning session with the administrators to plan how to best meet those objectives. The trainer can adapt this relatively open-ended session as needed, while still adhering to protocols, to plan to meet CCIT objectives. In addition, many of the objectives described in this session, such as creating partnerships with camp staff, will be goals throughout training.

First contact between camp administrators and CCIT trainers may be initiated in a number of ways. Initially, it is expected that CCIT trainers or other professionals, such as researchers, will contact camp administrators to introduce the program and seek to implement it. This is due to the fact that CCIT is a new program, and as of yet, has not been established or promoted among camp administrators. Those seeking to implement CCIT at camps may desire to do so for a number of reasons, including wanting to bring evidence-based treatments to settings which may benefit children and greater society, a desire to research a promising training program, or for any of a number of reasons which would lead to the professional contacting the camp administrator.

As the training program is implemented at different camp settings, displays efficacy, and is communicated among camp administrators, these administrators may contact those providing CCIT training to arrange for program implementation. When this occurs, this manual will be modified. For now, the procedures are written as if CCIT is unknown to camp administrators. Therefore, it will be necessary for the trainers to explain the program and establish connections with camp staff.

Pre-Training Preparation for Trainers

This section is included to provide information to trainers about issues that they may encounter when planning training and throughout the training session. This information will be helpful to trainers so they can make informed decisions when they encounter questions that are not addressed in the manual. One issue to consider in order to increase the success of the training program is to anticipate barriers to the adoption of evidence-based treatments (EBTs) that have been identified at other agencies.

In a review of these barriers, researchers identified one barrier as being that staff members lacked knowledge or skills to implement EBTs (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001). This barrier is addressed in PCIT and will be addressed in CCIT through the use of initial didactic instruction and later other training modules to build staff knowledge and skills. Another barrier to adopting evidence based treatments is that some staff members feel these treatments are too limiting or that they interfere with their work with the children. This barrier can be addressed when speaking with staff by communicating that CCIT is designed to help them address children's behaviors in a minimal amount of time, thereby helping the children to maximally participate in camp programming. In addition, PCIT was formulated with the goal of enhancing the relationship between caregivers and children (Eyberg, 2005).

Another barrier to the use of EBTs is that there is often a lack of a cohesive plan at a particular agency for how therapy should be conducted and which therapies should be used (Corrigan et al., 2001). This lack of a plan is believed to be due to a perceived lack of common interests between administrators and direct care staff, a lack of resources and time available to invest in implementing the treatment, and a lack of continuity in implementation of the treatment

(Corrigan et al., 2001). In CCIT, these issues can be addressed through the trainers communicating the expected benefits to staff, including expected reductions in stress and increased skills, among other reasons. With regard to available resources, there may be a difference between camps which are seasonal and provide training at the beginning of each camp season, and year-round camps, at which there is no scheduled training period.

At camps with a scheduled training before campers arrive, it is expected among staff that they will be trained in techniques for working with the children and staff will likely enter training without feeling fatigued or burnt out. There will likely be less need to invest in motivational strategies to elicit staff support in these types of camps. At camps which are year-round, there is typically no period devoted exclusively to training, and thus arrangements should be made with administrators to provide this time, ideally without creating too onerous a burden on staff in terms of requiring additional time or resources.

In addition, it may be necessary to attempt to motivate staff to participate in training. This can be done by communicating the expected benefits of training, as stated above. Finally, with regard to the issue of lack of consistency, PCIT is a unique treatment in that the skills utilized in it are to be used continually. There is no designated therapy session for staff to use the techniques with the campers. In addition, staff will be using these techniques in the presence of each other throughout the day, thus providing social reinforcement for the use of the techniques and increasing the perceived cohesiveness of the treatment.

These barriers to implementing EBTs have been reviewed here to elucidate potential barriers to the implementation of CCIT in a camp setting. Trainers should be aware of these potential barriers and be able to implement the strategies reviewed here for addressing these

barriers. Motivation to fully participate in CCIT is a topic that will be addressed throughout this manual to increase the participation level of staff.

Initial Communication Between Trainers and Camp Administrators

The first contact between CCIT trainers and camp administrators will require an introduction by CCIT trainers as to who they are and the purpose for their contact. This first contact will lay the groundwork for future collaboration, so it is important to begin auspiciously. Points that trainers should address in this initial contact are:

1. The trainer should introduce herself and state her professional title and role as a CCIT trainer.

2. She should then explain what CCIT is, which should include the following information:

> Counselor-Camper interaction training is a training program for wilderness therapy staff. It is based on parent-child interaction therapy, an evidence-based therapy for use with children with disruptive behaviors, which aims to enhance relationships between parents and children and help parents develop skills to reinforce appropriate child behavior and learn skills to address inappropriate child behavior. CCIT aims to help camp staff achieve these same goals in their work with campers. With the achievement of these goals, it is hoped that staff will be able to work most effectively with campers, be able to implement camp activities, and encourage maximum camper participation in these activities. In turn, this will help improve campers' functioning and camp experience.

The trainer should then indicate that she would like to describe the program in greater detail, including the specifics of training. Throughout the discourse with the camp administrator, she should be flexible to allow for questions from the administrator and to develop a relationship with the administrator through use of effective interpersonal skills.

A description of the training should include information on aspects essential to the successful implementation of the program, such as about the initial instruction in child-directed skills, discipline procedures, the use of in vivo training, and other important details that are

integral to the program. It should also be communicated that CCIT is intended to be a training program involving collaboration with camp administrators and incorporating feedback from camp staff into training to meet the unique needs of staff at each camp. CCIT trainers should convey that training can incorporate the unique culture of each camp. Trainers should make efforts to address any administrator concerns or issues which can help with program implementation without sacrificing training integrity.

From the beginning, the trainer should make an effort to develop what researchers have termed "true" partnerships (St. Pierre & Kaltreider, 2001). One factor helpful in building a successful relationship is identifying key contact persons at the target site. This contact person may be the administrator with whom the trainer has had initial contact. However, this contact person may be an individual who will work with the trainer at the camp, but who is not the administrator, such as might occur if the administrator is off-site during camp sessions. Identifying the contact person should be done during this initial contact between trainers and camp administrators. Having a contact person will help ensure that trainers are able to communicate with the camp as needed. Trainers should ask for the name and contact information of the person with whom they are expected to make contact and secure this information.

The researchers who implemented TCIT in a school (Gershenson, Lyon, & Budd, 2010) created trainings for teachers based on teacher interest and beyond the TCIT protocol as a way to involve themselves with the school and staff outside of the TCIT program. These researchers expressed that these efforts were helpful in creating a "true" partnership, as it demonstrated their commitment to the school outside of their personal interests in the TCIT program. Providing

these programs helped establish relationships with school staff and allowed them to give something to the teachers (training that was not motivated by researcher self-interest, but as a service to teachers). Providing these types of services to camp staff and making efforts to connect with them beyond the CCIT program may not be practical for CCIT trainers; however, efforts should be made to establish a "true" partnership with the camp staff. This can be done through providing information about the training program or topics related to the training or PCIT in general, contacting the site on a regular basis between the first contact and the beginning of training, and offering help in other reasonable ways based on camp needs, such as providing information about mental health-related topics.

Another method to facilitate staff investment in the CCIT training program is to illustrate the expected benefits to staff and the camp. As CCIT has not been evaluated as of yet, expected benefits are not able to be conclusively stated to camp staff; however, reasonable estimations of expected gains, based on research on similar program, can be conveyed. One expected benefit is the reduction in staff stress levels. As PCIT has been shown to lead to reductions in maternal stress levels (Hutchinson, 2006), due to increases in feelings of competence, increased skills, and reframing of child behavior, reductions in stress are expected to extend to staff as well. Another expected gain for staff is an increase in child behavior management skills that will be useful for them when working with youth with behavioral issues, as PCIT has been shown to be effective in reducing child disruptive behavior (Boggs et al., 2004). A final benefit is that PCIT has been shown to be effective in reducing incidents of child maltreatment (Chaffin et al., 2004).

These findings about the benefits of PCIT can be communicated to camp administrators, as similar benefits from implementation of the training program are expected. In addition, the

expected benefits can be communicated with camp administrators and staff throughout the training process to motivate staff to fully participate. St. Pierre and Kaltreider (2001) described the importance of enlisting upper level staff and management to support the program, as without their support direct support, staff may feel unmotivated to support the program. The importance of this support can be conveyed to camp administrators at this initial contact, as well as throughout training.

Upon agreement between trainers and camp administrators to initiate the training program, an initial consultation should be arranged to discuss the details of CCIT implementation at the camp site. Researchers emphasized the importance of giving staff what they desire from a training program (St. Pierre & Kaltreider, 2001). It is expected that much of these desires are congruent with expected program benefits, as stated in the previous paragraph. However, there are likely additional wishes that staff will have, of which administrators may be aware, that can be incorporated in the CCIT training program. This can enhance the acceptance of the training and the subsequent use of methods by trained staff.

When conducting an assessment of the needs of the camp, it can be helpful to assess a number of domains broadly. Directly asking what camp administrators may desire in terms of the training and how training can be adapted to best meet their needs may not elicit the most accurate or thorough answer. Administrators may not be proficient in analyzing their camp's needs, may not know enough about the training program to know how it can be adapted or what it will provide, and may not know information that could be important to share with the trainer. The trainer is encouraged to gather information about the camp within the following areas: the background and history of the camp, language or terms used specific to the camp, a description

of the campers who participate in the camp, the resources available, including a description of staff members, as well as equipment and facilities, the values and culture of the camp, the current training at the camp and the administrators vision for implementation of CCIT, and the desired outcomes of the training program (Scriven, 2007).

Gathering this information will help the trainer work with the administrators to personalize the training to meet the needs of the camp. Eyberg (2005) identified core features of PCIT essential to its success. These features are the use of the PRIDE skills, enhancing the relationship between caretaker and child, assigning homework, and the provision of in vivo feedback from the therapist to caretaker. When personalizing CCIT these features should remain unaltered.

Through the initial consultation, trainers and camp administrators will specify some of the modifications that will be made in their particular training program. The need for the modifications will become evident when information arises in the consultation that indicates a change to the CCIT protocol is warranted. An example of this might be that at a particular camp, particular language for asking a child to take a break during a period of noncompliance is already used. In an instance such as this, this language can be incorporated into the training program instead of using the conventional PCIT term "time-out." These details will emerge during a thorough consultation with the camp administrators in which the trainer assesses the needs of the camp within the above specified domains. Being able to accommodate the unique needs of the camp and incorporating the unique culture of each camp into the training program demonstrates a commitment to helping the staff. This will likely increase staff motivation to learn the skills in CCIT.

In addition to the modifications based on the details of the particular camp's needs, which will emerge during the consultation, there are expected areas of divergence from traditional PCIT, such as the lack of a timeout area, which will need to be addressed during the consultation. Trainers and administrators will need to plan for how the following changes to traditional PCIT protocol will be addressed at the particular site:

1. The size of the groups. In the manual for group PCIT group sizes of up to six parent-child dyads are recommended (Eyberg et al., 2009). In the TCIT training program, researchers worked with six teachers at a time (Gershenson, Lyon, & Budd). Thus, it seems reasonable that an appropriate sized group at a camp would be approximately six camp staff. Trainers can be flexible with this number if appropriate, such as if staff are grouped in teams of seven, it would be logical to work with a group of seven. Trainers and administrators should plan for the group sizes and how the group training schedule will be arranged so that all camp staff will be trained. Counselors should also be grouped by age of campers with whom they will be primarily working, with counselors working with children 8 years and above grouped together and those working with children younger than 8 years of age grouped together separately. Groups for counselors working primarily with campers 8-years-old and older should follow the procedures detailed in the sections "Working with Campers 8-Years-Old and Older" that are interspersed throughout the manual. The age 8 cut-off was determined through research on adapting PCIT with older children, in which it was found that adaptations to the PCIT curriculum were necessary for children age 8 and above (Chaffin, 2004; McNeil & Hembree-Kigin, 2010). If the camp structure is

such that counselors will be working with campers of all age ranges, grouping by age is not necessary, and all counselors should be trained in the adaptations for working with campers 8-years-old and older described in the CDI Instruction section.

2. Scheduling. CCIT will be conducted over approximately eight sessions, consisting of three direct teaching sessions, with coaching sessions in between teaching sessions. The first sessions at the beginning of each phase, termed "Instruction Session," will be conducted without campers. Therefore, arrangements should be made so that counselors can attend these instruction sessions without campers. Trainers and administrators should discuss this requirement and plan to provide coverage during these instruction sessions. It is possible to schedule trainings daily, so that the entire training period can last 8 days. For camps that have a training period before campers arrive, training that is not related to CCIT can be conducted at this time. In addition, it is possible to conduct CCIT over a shorter period of time, with multiple sessions per day, if it is desirable to complete training in a shorter amount of time.
3. Coverage of children while staff are practicing CCIT skills. Initially counselors will be coached working with individual campers. In addition, counselors will practice CCIT skills while doing homework individually with a camper. Coverage schedules should be arranged to permit the individualized coaching and homework, while ensuring that the remaining campers are able to be supervised. Schedules for when trainers can meet with camp staff should also be arranged so trainers can provide feedback to camp staff and discuss logistical issues. As it may be impractical for trainers to provide direct verbal feedback to camp staff during coaching sessions at

times, due to the need of staff to work with the children, trainers will record feedback in written form and discuss this with staff at a later time.

4. Space and materials needed. During normal PCIT, caretakers conduct special playtime with children while sitting in chairs at a table with three to five age-appropriate child toys. Where the counselors in CCIT will conduct the special play time during the coaching sessions should be arranged. Initially during individualized coaching sessions, the activity should be of relatively low intensity so as not to interfere with other activities or to draw other children to the activity. At the consultation, trainers and administrators should ensure that there are appropriate camp toys for use during playtime activities. The types of camp toys well-suited for this purpose are listed in Appropriate Toys for Special Playtime (Appendix C.1 and C.2). In addition, 2 two-way radios, with earpieces and microphones are required. This is so the trainer can communicate with the counselor whom he or she is coaching. This item will be supplied by either the camp or the trainer. The cost of this item is discussed in the Cost Analysis section of the dissertation that contains this manual (Syzdek, 2014).

Session 1

Camper Directed Intervention (CDI) Instruction

Session 1- Teaching CDI

Session Prerequisites

1. Arrangements will have been made to work with counselors without campers

Session Objectives

- Counselors will learn the PRIDE skills.
- Counselors will practice the PRIDE skills.
- Counselors will understand the reasons for using the PRIDE skills and for CCIT in general.
- Counselors will be prepared for the first coaching session.

Location

All instruction sessions should take place in an area removed from campers where discussion can be had in a conversational tone and information can be presented. There should be places where participants can sit down and where there is enough space for the group of counselors to practice role plays.

Session Outline

1. Direct Instruction of PRIDE skills.
2. PRIDE role-plays and practice.

3. Adjustments for counselors working with older campers presented.

4. Ignoring taught.

5. Homework is assigned.

6. Prepare for the first coaching session.

Session Materials

1. CCIT manual;

2. PRIDE Skills Handout (Appendix B);

3. Ignoring Flowchart (Appendix D);

3. CDI Benefits (Appendix E); and

4. Special Play toys (see handout for acceptable Appropriate Toys for Special Playtime; Appendices C.1 and C.2).

Procedure

Introduction.

1. Trainers and participants should introduce themselves, as this is the first time they will be working together in small groups. Trainers should attempt to incorporate an introduction activity typically used at the camp, such as stating names and a particular attribute or interest that the individuals have.

2. Trainers should begin by asking counselors about their training needs. Trainers should make a list of what counselors want from training. If it is possible to incorporate counselors' suggestions, trainers should make efforts to do so.

3. Trainers should introduce CCIT. Trainers should briefly describe the CCIT training as consisting of the main interventions, CDI, CODI, and a group management component. State that this particular intervention is the CDI phase and that counselors will learn the PRIDE skills for working with campers. Outcomes that counselors can expect to achieve during PCIT are to build good relationships with the campers and to effectively manage camper behaviors.

Trainers should state:

> Counselor-Camper Interaction Training, or CCIT, is a training program for wilderness therapy staff. It is based on evidence-based therapy for use with children with disruptive behaviors. Some of the goals and objectives of CCIT are to help you build good relationships with campers, help campers participate in camp programs, and reduce camper disruptive behaviors. Some of the benefits that are expected for you from CCIT are reductions in stress, more time for camp activities, and less managing disruptive behaviors, as well as increased skills in managing disruptive behaviors.
>
> Training is divided into three phases. The first phase, camper-directed intervention (CDI), is focused on building the relationship between you and the campers. During this phase, you will be taught skills for engaging campers and encouraging positive behaviors while they play. I (trainers) will then coach you for two sessions while you practice these skills with campers. During the next phase, counselor-directed intervention (CODI), you'll be taught effective ways to discipline campers. And again you'll be coached in the administration of discipline procedures. The final phase is targeted towards a specific issue at camp, which is (identified targeted area). During this phase you'll be taught group management techniques, based on CCIT methods. Throughout the training period you'll also have homework where you'll be practicing the skills you learn. I'll be asking you to practice the skills that you're taught repeatedly during training so that they will begin to come naturally to you outside of training. You'll not be expected to practice them as frequently outside of the special playtime sessions you'll have with campers for training and homework. Some of the behaviors that I'll ask you to do or not do, including for example, giving commands, are acceptable to do outside of training to help manage campers, but we'll practice other things you can do to help campers meet your expectations in training.

4. Trainers should introduce the day's session, CDI Instruction. Trainers should explain why CDI is taught first. They should read:

CDI is the first phase of training because it helps to develop communication between counselors and campers. In addition, CDI helps build the relationship between counselor and camper and helps the campers to enjoy spending time with counselors, which will be helpful for practicing CCIT.

CDI helps counselors develop positive behavior management techniques, which help to avoid feelings of frustration in both counselors and campers, and leads to increases in camper self-esteem. These positive reinforcement skills will be necessary when you begin the next training phase, CODI, and begin to develop camper behavior management skills. Some of the benefits of CDI are…

Trainers should then hand out the CDI Benefits worksheet (Appendix E) and point out the listed points as the script addresses them:

CDI can:

- Help communication and maintain camper attention;
- Build camper/counselor relationship;
- Improve camper enjoyment with counselor;
- Provide positive behavior management techniques;
- Lead to improved camper self-esteem/decreased frustration; and
- Provide necessary skills for CODI.

5. Introduce the targeted behaviors of CDI.

a. Hand out PRIDE sheet listing Don't and Do Behaviors. The PRIDE skills are originally listed in the PCIT Manual (McNeil & Hembree-Kigin, 2010). However, the way the skills are taught, with additional explanations and examples, is different in CCIT than in PCIT. There is also a specific script in CCIT for teaching the skills.

b. The trainer should reference each skill that is listed as follows.

c. Trainers will read the indented portion of the following script aloud and teach each of the behaviors

Don't Behaviors

A. Commands

First, here are some behaviors to avoid when interacting with the campers, when practicing CDI skills. The reason to avoid these behaviors is because they can create an experience for campers that isn't fun or can remove the control of the play from the campers.

First, avoid commands. Commands are when you tell the camper to do something. They are not helpful because they don't let the camper lead the activity. Also, if the camper does not respond to the command, then a negative situation has been created, which is not the purpose of CDI. Commands come in two forms, indirect commands and direct commands.

A direct command is when the counselor tells the camper to do something, for example, "Give me the block." Indirect commands are more subtle and use language which gives the appearance of giving the camper a choice, but still put the control of play in the hands of the counselor. Here is an example of an indirect command, "Why don't you color this part red?" Do you see how the statement actually is a suggestion by the counselor and takes the control away from the camper to color the picture anyway he wants, or not to color at all? I will now read a list of statements and I want you to tell me if they are direct commands, indirect commands, or no command.

The trainer will read the following statements and elicit answers from each of the counselors, perhaps asking each counselor in turn. The trainer should supply the correct answer if no answer is given or if the wrong answer is given. If more than half of the answers are wrong then the trainer should again explain what direct and indirect commands are and re-read the statements with slightly different wording and elicit answers one more time.

"Please put the marker back in the box." – Direct command

"How about making that paper into an airplane?" - Indirect command

"That's a nice picture you colored." – No command

"Let's make animal noises." – Indirect command

"Those were great animal noises you made." – No command

"I'd like you to make animal noises." – Direct command

B. Questions

The next type of behavior to avoid is questions. Much like commands, questions also take control of the play away from the camper and put it in the hands of the counselor, and can indicate that you aren't following the camper. One type of question is one which directly asks for information, such as, "What shape did you just draw?" You can see this question calls for a response from the camper, which does not allow the camper to be in control.

Another type of question which is less obvious is one that is asked with a rising intonation at the end of the sentence. These types of questions appear to be statements, but in reality the rising intonation suggests that an answer is expected from the child. The sentence, "You're drawing a lion" (Read with rising intonation on the word "lion") appears to be a statement, but calls for the camper to confirm or deny that he is actually drawing a lion, again taking control away from the camper. Here are some statements. See if you can tell me if they are questions or not questions.

Trainers will read the following statements and provide the correct answers after counselors have given their responses.

"It looks like you're building an arts and crafts project, aren't you?" – Question

"You're making the doll go on a camping trip." – No question

"What is this part of the picture of camp supposed to be?" – Question

"You're singing a camp song."- No question

"You're getting out the clay." (Read with rising intonation on "clay.") – Question

C. Criticisms

The final type of behavior to avoid is criticisms. A criticism is a negative statement directed towards the child or towards what he is doing. The purpose of criticisms is to point out mistakes and tell the child what not to do. Criticisms result in the child experiencing a negative interaction and having lowered self-esteem. Examples of criticisms are: "That's not the right color for an alligator," or "Don't color so quickly." For a change, I am going to read some scenarios. See if you can make a criticism from the behavior the child is demonstrating. Remember, we don't want to actually say these things, this exercise is just to illustrate what criticisms are.

Trainers should read the following scenarios and ensure that counselors answer with a criticism similar to the one listed or provide these as answers:

The child is cleaning his bunk and making his bed the wrong way. "You should put your blanket the other way."

The child is not tying a knot correctly, as should be done when camping. "That's not the correct way to tie a knot."

The child is coloring outside the lines. "It would look better inside the lines."

Review Don't Behaviors: "OK, those were the behaviors we should avoid in CDI. Again, what are they?" (Trainers ensure that counselors mention all three of the Don't Behaviors.)

Do Behaviors

Introduction:

> Great, now that we have talked about what we don't want to do, let's talk about what we do want to do in CCIT. The behaviors that we do want to do are represented by the acronym PRIDE, which stands for Praise, Reflect, Imitate, Describe, and Enthusiasm. We will talk about each of these behaviors in detail.

A. Praise

The first behavior that we should try to do in CCIT is praise. Praise is complimenting campers on behavior that they have done well. There are two kinds of praise, unlabeled praise and labeled praise. Unlabeled praise is a general type of praise that lets campers know they did something well, but not necessarily what it was. For example, "Good job" or "Way to go!" can make campers feel good, but not necessarily let them know what they did well.

Unlabeled praise is good, but labeled praise is better because it lets campers know exactly what they did well. This helps ensure that this good behavior continues. Here are some examples of labeled praise: "You did a nice job of putting that piece in the puzzle," or "You are working hard to build that tower." Let's see how many different ways we can praise a child for some of these behaviors. I'll read a scenario and I'd like each counselor to respond with a labeled praise. Let's try to come up with many different ways to praise."

Trainers will read the following scenarios and each counselor will respond with a Labeled Praise.

The goal here is to develop a repertoire of labeled praises.

The camper draws a picture of his friend doing a camp activity.

The camper shares the clay with the counselor.

The camper is creating a scene where two dolls are going to camp.

B. **Reflection**

Reflection is rephrasing what the camper says. For example, if the camper says, "I finished the puzzle," you could say, "Yes, you finished the puzzle." Another example would be if the camper says, "The lion goes 'Rawr!' then you might say, "The lion goes 'Rawr!'" Reflection shows campers that they are being heard as well as allows them to see what their play and behavior looks like.

C. **Imitation**

A behavior that is similar to reflection is imitation. As with reflection, the goal of imitation is to show campers that you're paying attention to them and that you approve of what they're doing. It also shows the campers that they are creating a fun activity that other people would like to do, a skill that will be helpful when they are playing with other

campers. When you imitate, you are doing what the camper is doing. For example, if a camper is building a house with blocks, you might also get blocks and begin building a house like the camper is, stacking a block on top of the previous one, just like she does. Let's practice reflection and imitation by going around in our circle and having a counselor come up with a statement or activity that the next counselor will then reflect or imitate.

Trainers will ensure that each counselor comes up with a statement or behavior and that the next counselor reflects or imitates correctly and give feedback as necessary.

D. **Describe**

The behavior "describe" is just what it sounds like. You will describe to the campers what they are doing. It's almost like the campers have their own commentator giving a play-by-play account of what they're doing. The campers will feel good that someone is that invested in what they're doing to be able to describe their actions. It will also help them concentrate on what they're doing and help them connect language with actions. You don't have to only describe big actions, such as putting a piece in the puzzle, but can describe each action, "You're looking for a piece in the pile." "You're flipping over other pieces, looking for the right one." "You found a piece and are now trying it," and so forth. Here at least three descriptions are given for one action. Let's build up our ability to describe in detail by trying to come up with five descriptions for what another counselor is doing. I'll call one counselor to perform some action and another counselor will come up with five descriptions. Try to be detailed in a short period of time.

Here the trainer should make sure that each counselor gives five descriptions of the actions of another. Trainers can supply some actions for counselors who are having trouble.

E. Enthusiasm

The last PRIDE skill is enthusiasm. I bet because you all are camp counselors you are already pretty good with showing enthusiasm with the campers. And I'm sure you've all seen how the campers respond when you show enthusiasm. They feel excited about what you all are doing and happy. You don't have to go overboard to show enthusiasm. Smiling, showing interest in your voice, and body language are all ways to show enthusiasm.

Review

> That was all of the PRIDE skills. Let's review again what they are. (Here the trainer will make sure that counselors identify the correct skill for each letter in the acronym.) P-Praise, R-Reflection, I-Imitation, D-Describe, E-Enthusiasm. Why don't we review these by playing some PRIDE charades? The trainer will pretend to be a camper engaged in some activity. Each counselor will demonstrate one of the skills and the first counselor who identifies what this counselor is doing will then get to demonstrate one of the skills.

Trainers make sure the skills are demonstrated properly and that counselors are identifying them correctly. Trainers should also ensure that each counselor is able to identify a skill and that if some counselors don't answer they are called on so they have a chance to answer.

For Counselors Working with Campers 8-years-old and Older

For counselors who are working with campers 8-years-old and older, some modifications and additions to the above instructions are necessary, based on modifications suggested by researchers studying PCIT for older children. These modifications will build off of skills discussed above. Therefore, counselors who work with campers above age 8 should participate in the above training, as well as in these additional training sections. For counselors who only work with campers younger than age 8, trainers should skip this section. If counselors work with campers both younger and older than age 8, both sections should be administered.

In general, some of the adjustments that are necessary for older campers are to adjust the frequency and type of PRIDE skills used, modify the way commands are given in CODI, modify the length of time ignoring in CODI, modify the type of toys that are used and to adjust the timeout procedure to be safer for use with older children. The timeout procedure is modified in

CCIT by not having a counselor put hands on children, as parents would in PCIT, during a part of the timeout sequence.

Trainers should first begin by giving counselors information about the adjustments necessary for working with older campers. Trainers should say: "Now, I want to talk with you about working with campers age 8 and older. There are some adjustments to make to the skills that we already talked about to make the skills more effective for use with these older campers."

Frequency of use of PRIDE skills. The first adjustment is that the expected frequency of use of PRIDE skills is less with older campers than with younger campers. Older campers tend to appreciate less frequent verbalizations, allowing them to think about their own play.

> The first difference between working with older campers compared with working with younger campers is that it is not necessary to use the PRIDE skills as often. Older campers will likely find too frequent use of the PRIDE skills intrusive to their play. Therefore, reduction of the frequency of PRIDE skill use is addressed in a discussion of each of the separate PRIDE skills, along with other adjustments, which we will cover now.

Praise

Using praise that is targeted for younger campers might be off-putting for older campers. Older campers typically value less frequent and more age-appropriate praise. Therefore, the expected frequency of praise will be less for older campers and age-appropriate praise will be expected.

> The first change for older campers is that it is not necessary to praise as often as with younger campers. Older campers might find it intrusive to have frequent praise so it is desirable to only praise campers after they have done something significant for their age level. For example, you might praise a younger camper for putting each piece of a puzzle together. An older camper might find that kind of frequent praise to be patronizing.

> Therefore, it would be desirable to praise him if he put a piece in the puzzle that was hard for him to find, or when he has completed a portion of the puzzle.
>
> Second, the type of praise that older campers value will likely be different than the type of praise younger campers value. Older campers can understand what more general, less specific praise, is intended to praise. For example, older campers can understand that saying "Good job," while they are putting together a model, means that they are doing a good job putting together the model. In addition, older children might value non-verbal praise, as well. This could include a fist-bump, a high-five, or a wink. What other types of non-verbal praise do you think would be valued by older campers?

Here trainers should pause to allow counselors to generate a list of non-verbal praise. Types of non-verbal praise that might be identified include: a "thumbs-up," other hand gestures, and other displays of congratulations.

Trainers should also discuss that older campers' reactions might not be the same as younger campers. Older campers might appear to reject praise that counselors give. Counselors should make efforts to adapt praise to fit the campers' desires. However, counselors should also be aware that while older campers might give the appearance of rejecting praise, they may actually value it.

> Sometimes it might seem like the praise you give older campers might be bothering them. It is important to try to adapt the praise to suit the camper's preference. For example, if the camper seems bothered by praise that seems too childish, try some more age-appropriate praise or perhaps some of the non-verbal praise we identified. However, older campers might often give the appearance of devaluing praise, when in fact they really enjoy it. Many children who have had difficult early experiences have not had this type of praise in their past, so when they receive it, it can feel uncomfortable at first, but it really fills a need they have for it.

Reflection

When reflecting with older campers, counselors should summarize rather than repeat sentences of campers. The reflections can also add to what the camper has said.

When using reflections with older campers, it is not appropriate to repeat every sentence that the camper says. Older campers can remember what they have said for several sentences, therefore summarizing what they say can be more effective, and feel less intrusive, than reflecting after each sentence the camper says. For example, if the camper says, "I'm building this race track for these dirt bikes to race on. They sure will go fast. I'm making this jump really tall," instead of repeating each sentence, a good reflection might be, "You're building a really exciting racecourse for those bikes."

Another way to reflect is to add additional information to what the camper said. So if the camper in the previous example said what he said about the racecourse, another way to reflect that might be, "You're building a big jump. I bet the dirt bikes are really going to fly off that."

Imitation

Imitation should be modified when working with older campers to be less imitative and more parallel of the camper's play. This is because older campers can recognize that the counselor is capable of generating his own ideas when playing. Therefore, the camper might find it patronizing to have the counselor imitating all of his movements. However, counselors should focus on playing at the same level as the camper, and not "outdoing" the camper's play.

When using the imitation skill, you should directly imitate the camper less, and play parallel with them more. This is because the camper can recognize that you can come up with your own ideas for play and values your contributions to the play. On the other hand, it is important not to "outdo" the camper and play in a way that is too advanced for him. For example, if the camper is building with blocks, instead of putting a red block on a blue block, such as the camper may be doing, you can build the same type of structure the camper is making. For example, if the camper is making a fort from the blocks, you can also make a fort or similar structure, although the sequence of construction or materials may be varied compared to the camper's fort.

Describe

When using the skill "describe," it is advisable to avoid describing the older camper's behavior in minute detail and also avoid describing strictly behavior. Instead, counselors should

describe camper behavior more sporadically and describe other facets of the play, such as information about the play.

> When using the skill "describe," again, you should reduce the frequency of its use. Many older campers would find it distracting to have every behavior described and they are able to recognize that you remain present with them, even though you aren't frequently commenting on their actions, as you would with a younger camper. Therefore, pause when describing behaviors. In addition, you can describe other things related to the play beside behavior. For example, a string of descriptions with a younger camper might sound like this, "You're putting the clothes on the figure. You're straightening her hair. You're bringing her to the tea party." Here you are describing each behavior in detail. With an older camper the descriptions might sound as follows, "You're getting the doll ready. She looks really pretty. She's going to the party. I bet she'll have a good time." This style expands the way of thinking about the play beyond simple behavioral descriptions and enhances the imaginative play for the older camper.

(End of section for counselors working with campers 8-years-old and older.)

Ignoring. (Refer to Ignoring Flow Chart [Appendix D], based on Ignoring Flow Chart in McNeil & Hembree-Kigin, 2010).

> Sometimes during play, despite our best use of the PRIDE skills, a camper will still act in inappropriate ways, such as by whining or yelling, for example. We want to respond to this behavior by ignoring it when possible. The reason for ignoring it is that when campers do not receive attention for this behavior, they will likely stop it in favor of behaving in ways which get them attention. You will already have demonstrated that a camper will receive attention from doing on-task behavior with your use of the PRIDE skills. The key to ignoring is to continue until the camper behaves appropriately. Often, the negative behavior will increase as the camper tries to get attention. It is important to continue to ignore this behavior. However, once the camper behaves appropriately then immediately give him positive attention again. I will demonstrate this sequence with a counselor acting as a camper. First, we will perform the sequence at regular speed. Then we will slow down and describe what we are doing at each step.

The trainer will demonstrate a scenario in which ignoring is used. The first sequence will be performed at regular speed and then the second will involve an explanation of each step of the intervention. The trainer will be a counselor and a counselor will pretend to be a camper. The

trainer will direct the counselor in the type of behavior he or she would like the counselor to display.

Trainer*:*

> In this scenario, I will be the counselor and one of you counselors will pretend to be the camper (The trainer should assign one of the counselors to pretend to be a camper). We are in the middle of special play time. During this time, the camper has been playing with a puzzle and doing well, but then begins to yell. Watch how I use ignoring to avoid giving attention to this behavior.

One of the counselors will pretend to be the camper, putting pieces of a puzzle together. During this time the trainer, playing the counselor, should use the PRIDE skills to reinforce this on-task behavior, by saying something such as, "You're putting the piece into the puzzle. It looks like it fits! Wow, you're so smart to put the piece in the puzzle like that. Oh, it looks like you're looking for another piece," and so forth. The trainer should direct the counselor to pretend to be putting the puzzle together. After about 2 minutes of this behavior, the trainer should direct the camper to begin yelling.

The trainer will demonstrate ignoring by not saying or doing anything during this time. The camper should be guided to demonstrate escalating behavior by continuing to yell and to increase volume, looking at the trainer to try to get a reaction. The trainer will continue to ignore. At this point the counselor will stop yelling and looking around begin to put pieces of the puzzle together. At this point the trainer should immediately reinforce this behavior by using a labeled praise, "You're doing a great job putting the puzzle together now. I'm glad to see you playing so nicely."

Now the trainer and counselor will replay the scene describing what is happening. The counselor will begin by putting together the puzzle. The trainer will say to the counselors, "Here the camper is on-task, playing nicely. I use the PRIDE skills to reinforce what he is doing." The trainer will use the PRIDE skills, such as those described above, to reinforce the counselor's behavior.

At this point, the counselor will begin to yell. The trainer will explain*:*

> Now the camper is beginning to yell, which is not an appropriate behavior. I will not attempt to correct that behavior. Rather, I will ignore the behavior. I ignore by not talking to the camper, maintaining neutral body language, and averting my gaze from the camper.

The trainer demonstrates these behaviors as the counselor continues to yell. The trainer says:

> It is often the case, especially when ignoring the camper for the first time, that the camper's negative behaviors will increase. This is likely because in the past the child was rewarded with negative attention for performing these behaviors as an adult attempted to "correct" the situation by trying to make him stop the negative behavior. So when I ignore the behavior, the camper attempts to get my attention by yelling more and louder. It is important to continue to ignore this behavior to show consistency.

The counselor continues to yell, while the trainer ignores.

> It can be hard to ignore this negative behavior sometimes, but it is critical to continue to ignore, as this will establish what the camper can expect when he acts out. While I am ignoring, I am looking for the first sign of positive behavior. The instant I see positive behavior I want to stop ignoring and reinforce this behavior with the PRIDE skills.

The counselor will stop yelling and look around, see that she is not getting a reaction from the trainer, and then pick up a puzzle piece. At this moment the trainer will again use the PRIDE skills, such as stated above, to reinforce the counselor. The trainer will tell the counselors:

> See, I have not mentioned the past negative behavior, I've only reinforced the current positive behavior. And as you can see, the camper has responded by continuing to play with the puzzle. That's because getting this positive attention feels good. This is the goal

> of the CDI sessions. Later in CODI sessions, we will learn other ways to manage disruptive behavior, but ignoring is a positive tool to avoid giving negative attention and continuing to make the session fun for the child and develop the relationship.

Behaviors that can't be ignored. Here the trainer will instruct the counselors about camper behaviors that can't be ignored, when the camper is being aggressive or destructive, why these behaviors can't be ignored, and what to do about these behaviors.

> Many negative camper behaviors can be ignored. However, there are some behaviors that counselors can't ignore, such as when the camper is being aggressive, destructive, or leaving the area. Examples of aggressive behavior are the camper hitting or kicking you. Destructive behaviors might consist of the camper trying to break the toys. Finally, if the camper leaves the special play area and goes away and out of sight that can be unsafe and so that can't be tolerated.
>
> When these behaviors occur, the counselor will let the camper know that special play time is over by saying, "Special play time is over because you (name the unsafe behavior). We will try special play time again tomorrow." It is important to let the camper know that special play time is over because this unsafe behavior can't be tolerated. It also lets the camper know that the following steps you will take to address this behavior are not part of your special play time. At this point you will follow (camp name)'s protocol for addressing this unsafe behavior.

It will be important for trainers to have learned what the camp's protocol for managing unsafe behaviors is. Many camps follow a standardized procedure for managing this behavior, which typically consists of a sequence of behavior ultimately resulting in physical restraint for continued unsafe behavior. Trainers will name this protocol as what the counselors should do when they encounter unsafe behaviors during CCIT sessions.

Trainers will now lead a discussion about using ignoring as a technique for managing negative behaviors. In past research literature it was found that many participants had issues with ignoring negative behaviors and felt that it was their duty to "correct" these behaviors by responding to them. Some counselors might feel the same way so it is important to address these

concerns at this point and remind counselors the purpose of ignoring, which is to reinforce the camper's positive behaviors, make special playtime enjoyable, and build the relationship between camper and counselor. Trainers can begin by asking counselors, "Now that we've discussed the technique of ignoring and what behaviors to ignore are there any questions about it?" Trainers will answer questions that counselors ask, referring to information contained in the training manual to answer questions.

Trainers will then open the group to questions from the counselors and have a discussion about their attitudes towards ignoring by first asking, "What do you all think about using ignoring?" and then further addressing concerns by asking, "Do you have any concerns about using ignoring?" Counselors may bring up concerns that ignoring negative behaviors is tantamount to allowing these behaviors. If counselors do not bring these concerns up, trainers can say:

> One of the issues people have with ignoring sometimes is that they feel children are being "allowed" to behave negatively without this behavior being corrected. Does anyone feel this way? It is a legitimate concern. But remember that the point of CDI is to build the relationship between the camper and staff, which will help the use of other techniques for discipline later on in CODI. In addition, research has shown that using the technique of planned ignoring and positive reinforcement, through the PRIDE skills, is effective in improving child behavior. So it is important to know that ultimately child behavior will likely improve. However, using some of these strategies might feel a little unnatural at first. So, let's practice ignoring with partners.

Counselors should practice ignoring with a partner, using the same format that the trainers illustrated. Trainers should observe to ensure that counselors are performing ignoring properly, and direct counselors by saying:

> I'd like you to practice ignoring just like we demonstrated. One partner should be the counselor and the other should be the camper. The camper should begin with on-task behavior, to which the counselor should respond with the PRIDE skills. The camper should then begin to behave negatively, but safely. The counselor should use ignoring at

this point and continue using it despite continued, or even increased, negative behavior by the camper. The camper should then behave in a positive way, such as by returning to the task. The instant the camper behaves positively the counselor should give a labeled praise about what the camper is doing that is the opposite of the negative behavior. Both partners should play the role of camper and counselor in two role plays.

Coaching Practice

Trainers will now have counselors practice the CDI skills in role-plays. Trainers will inform counselors that they will be practicing the skills in role-plays much like they will be with campers. Trainers will instruct counselors on how to conduct special play time with campers and how counselors will be coached by trainers via two-way radio while they are having special play time with campers.

> Now that you have learned all the skills for CDI, I'd like to have you practice them with each other. This will also introduce how we will practice them with the campers in coaching sessions. You will practice the skills in special play-time sessions with campers with coaching from me. Special playtime will consist of one camper and one counselor sitting together in a space away from the group with several toys available for the campers to be able to play with the counselors.
>
> During special playtime, counselors will be attempting to use as many of the PRIDE skills as they can while avoiding the Don't Behaviors and using ignoring when appropriate. These coaching sessions will typically begin with a 5-minute observation period during which I will record the number of PRIDE skills and Don't Behaviors you use. I will then give you feedback about your performance and how close you were to specific goals in each category. I will inform you about your target goals at the end of this session.
>
> After the observation period, the coaching session will then begin, where one of us trainers will be sitting close and giving you feedback about how to use the PRIDE skills. To illustrate this process, I'd like to practice as a group. One counselor will pretend to be the camper and one will be the counselor and conduct special playtime while I am coaching him or her. The rest of the group will observe the session and then we will discuss what happened. Who would like to go first?

Two counselors should begin a role-play, with one counselor playing the part of the camper and the other the counselor. The trainer will instruct the counselors how to begin special

playtime: “I’d like you to sit next to each other at the table. The toys will be on the table. I’d like you, the counselor, to say to the camper, “Now we will begin special playtime.” The trainer should pause to let the counselor repeat this to the camper and do so for each of the following instructions to be repeated:

> The rules of special playtime are, first, you must sit at the table (or other sitting area, such as a bench or blanket). Second, you must play nicely. Finally, if a toy falls on the floor it stays on the floor.” Now you will begin special playtime with the camper and try to use as many PRIDE skills as you can.

Now trainers will begin coaching counselors on using the PRIDE skills. Role-plays should last approximately 5 minutes. While the role-play is happening and one of the trainers is coaching, the other trainer can be describing what is happening, answering questions, and explaining things to the other counselors, who are observing the role-plays. Co-trainers can explain why the trainer is giving a certain type of feedback, such as by saying, “The trainer is asking the counselor to give a labeled praise here when he says to the counselor to say, ‘Good job racing that toy car.’” Co-trainers can also point out the rationale for using certain PRIDE skills, such as saying, “When the counselor plays with the animals the same way as the camper, the camper really feels special.” It is anticipated that observing the role-plays will be instructive for the counselors, as they will learn vicariously by observing the role-plays, coaching, and co-trainer feedback.

After the role-plays are complete, trainers should take questions from the counselors and explore what that experience was like for them. Counselors may remark that many PRIDE behaviors were expected of them in a short amount of time. If counselors do not comment on this spontaneously, trainers should broach this subject. Trainers should talk about the concept of

overlearning and how overlearning helps counselors to be able to use these skills naturally in their work outside of CCIT sessions. To talk about this topic trainers should say:

> There were certainly a lot of PRIDE skills expected in a short amount of time. The reason for this is so that these skills can be overlearned. Overlearning is when you learn to do something an excessive number of times so that you will naturally do it a moderate number of times. We don't expect you to do that many PRIDE skills all day long. You would likely be exhausted by the end of your first day! However, by having special playtime for short amounts of time it gives you a chance to really focus on using your PRIDE skills during that time. That's why one of the things we will ask you to do is to do special playtime with campers for 5-minute sessions for homework after each session of training.

Homework

At this point trainers should discuss the homework that they'd like the counselors to do before their next meeting. Trainers should help counselors plan how the homework special playtimes will be conducted and what is expected to happen during this time:

> I'd like you to practice the CDI skills that we covered today in a special playtime session with a camper before we meet next time. The first thing to think about is when special playtime can happen. Special playtime will take only 5 minutes with the camper. However, setting up the special playtime materials, getting the camper, and returning the camper to regular activities will also take time, perhaps another 10 minutes. In addition, the time you can play with the camper is not limited to only 5 minutes. You and the camper may continue to play and that is fine. However, because I want you to concentrate on using the PRIDE skills at a high frequency, the special playtime itself will only last 5 minutes.
>
> This activity should be concluded after 5 to 10 more minutes, however, in order to end the activity successfully and so the camper associates special playtime with fun. It should occur in an area away from other campers and counselors where there will be no distractions. Possible areas might include a blanket set-up on the ground, a picnic table, or on a bench outside the cabin. When will it be possible for each of you to have special playtime during the day? Please write this time down on you special playtime homework sheet.
>
> Next, you will choose a camper with whom you will have this special playtime session. Each of you should choose a different camper so that many different campers have a chance to participate in special playtime. Also, you should try to choose different campers throughout the training sessions so that you gain experience working with a

> range of campers and develop good relationships with many campers. Who you choose for special playtime is up to you. However, a factor that you may consider in choosing the camper is that you may want to use special playtime as an opportunity to have individual time with a camper. You may want to have this time because the camper has expressed an interest in doing something with you, you would like to give a reward to a camper, or perhaps if you have had a difficult time in the past with a camper, this is a chance to build your relationship. Please consider with which campers it would be best to work when planning special playtime sessions and discuss your choices with your fellow counselors, so that different campers are selected throughout sessions.
>
> You will also inform campers that these special playtime sessions will be happening. A good opportunity to talk with campers about this could be at a bunk meeting or at a mealtime. You should inform the campers that different counselors will be meeting with different campers in the coming days to do special playtime with them. You should explain that special playtime is an opportunity for the campers to play with the counselors in a one-to-one setting. All campers will get a chance to participate in special playtime in the coming days. Counselors should ask campers if they agree to do special playtime with them and notify the campers when they have the special playtime planned. Please consider now the camper with whom you'd like to do special playtime, discuss your choice with your fellow counselors, and write your choice on your homework sheet.

Here trainers should utilize the information they have gained from talking with administrators to work with counselors to determine when it is feasible to have special playtime. Counselors will likely benefit from having a discussion as a group about when it is possible for each of them to have special playtime as provisions for coverage of the remaining campers, feasible times of day, and other logistical issues will need to be considered.

Once the counselors have all planned when they will have special playtime, trainers should discuss how to conduct it:

> For special playtime, I'd like you to prepare some toys that you and the camper can use. These toys should be something that the camper can be creative with and doesn't have to follow rules. The toys should not be overly stimulating, so that the camper would have a hard time playing gently. Some examples of good toys to use are listed on this sheet. Examples may include art projects, dolls, blocks, or other similar toys. There may be a camp activity that could be incorporated as a toy, such as an art project that was done in arts and crafts or making a decoration for the cabin. Once these toys are chosen you will bring the camper to the special playtime area and tell her about special playtime and the rules. The instructions are listed on the homework sheet and are, "Special playtime is

now starting. The rules of special playtime are, first, sit in the seat. Second, play nicely. Third, what falls on the floor stays on the floor." At this point you can prompt the child to begin playing. You should keep track of the 5 minutes with a watch or other timer. During this time you should try to use as many of the PRIDE skills as you can, while avoiding using the Don't behaviors. At the end of the 5 minutes announce, "Special play time is now finished." Record that you have completed the special playtime on this sheet and note any significant issues you observed, such as if the camper responded well, if you had problems using one of the PRIDE skills, or anything else that occurred or about which you had questions. Please bring your completed homework sheet to the next session, and each completed homework sheet to each session afterwards. Do you have any questions about how to do the homework?

For Counselors Working with Campers 8-years-old and Older

For all homework assignments, the following adjustments will be made for counselors working with campers 8-years-old and older. The types of toys that will be used for this group of campers will be more advanced and engaging than toys used for younger campers. Therefore, toys which may be considered "too chaotic," and listed in this category as inappropriate types of toys for younger campers in the handout "Appropriate Toys for Special Playtime for Younger Campers" (Appendix C.1) are considered appropriate for older campers, if campers are deemed mature enough to handle them. In addition, the length of special playtime will be extended for older children.

For those of you doing special playtime with older children, the types of toys that you will use for special playtime will be more age appropriate. See the sheet titled, "Appropriate Special Playtime Toys for Older Children (Appendix C.2)." Toys that older children will value playing with will be more advanced than those used for younger children. Some examples of these include models or more intricate toys, such as connecting building blocks. As with younger children, these toys should allow both of you to participate and be relatively free of constraints, such as rules. Therefore, video games or board games are still not good choices for special playtime.

In addition, older children tend to play for longer periods of time. Therefore, it makes sense to schedule longer special playtime sessions to allow children more time to do their activity. However, you will still limit your practice of the PRIDE skills to 5

> minutes, in order to concentrate on using as many as you can during this period of time. You will announce to the camper after 5 minutes that special playtime is over, but that he may keep doing whatever activity you have begun. This activity should be concluded after 5 to 10 more minutes, however, in order to end the activity successfully and so the camper associates special playtime with fun.

(End of section for counselors working with campers 8-years-old and older.)

Planning for the First Coaching Session

Trainers should give counselors information about the next day's coaching session and how the session will be conducted. Trainers and administrators will have already identified a particular period of camp in which coaching can take place, a period in which the type of activities appropriate for special playtime. Trainers should give counselors the following information:

> Next time we meet, we will have a coaching session. The coaching session will begin with one counselor and camper separating from the group and having a coaching session with me (trainer). We will then record how many times you can use the PRIDE skills in 5 minutes, so your homework will be good practice to try to increase the frequency of your use of the skills. Each of you should decide who one camper in your group is that you can do a coaching session with tomorrow. All campers should have a turn doing the special playtime sessions. Also you should decide the order that you will have the sessions. The total session will be about 20 minutes per counselor, which includes a couple minutes to go over homework, a 5-minute observation session and a 13-minute coaching session.

At this point, trainers should make sure that counselors choose the order in which they will go for the coaching the next day so the coaching can begin immediately at the start of the period. Trainers should also ensure that counselors have chosen a camper with whom they can have a coaching session and should indicate this information on the schedule sheet. "That concludes our session today. Thank you for your participation. We are off to a good start."

Session 2

1st Camper-Directed Intervention (CDI) Coaching

Session Objectives

- Counselors will increase their understanding of CDI skills by reviewing homework assignments with the trainer.
- Counselors will know how close they are to CDI mastery goal.
- Counselors will improve their use of CDI skills through feedback.

Session Outline

1. Trainers will review homework with counselors.

2. Trainers will code counselors in their use of CDI skills.

3. Trainers will coach counselors in CDI.

4. Homework is assigned/Next session planned.

Session Materials

1. CCIT manual;

2. Appropriate Toys for Special Playtime Sheet (Appendix C);

3. CDI Special Playtime Homework Sheet (Appendix F); and

4. CCIT Dyadic Counselor-Camper Interaction Coding Sheet (CCIT DCICS) coding sheet (Appendix G).

Session Preparation

Prior to the session, trainers should ensure the area designated for the coaching session is prepared. To do so, trainers will need to ensure that there is a space available for the camper and counselor to have a special playtime session, sitting across from each other, with a place to sit for the trainer. This area should be removed from other distractions, such as other campers and counselors. There should be appropriate toys available, such as those indicated on the Appropriate Toys for Special Playtime (Appendices C.1 and C.2). Trainers should have all materials indicated above.

Trainers should first welcome the camper and counselor to the special playtime area. The trainer should indicate that the camper and counselor should sit down. The trainer should then introduce herself and explain to both camper and counselor what will happen during special playtime by saying the following:

> Hello, I'm (trainer's name). I'm going to be working with both of you while you have "special playtime." Special playtime is a time you (directed at the camper) will get to play with toys with the counselor. While you're doing that I'm going to be sitting to the side of you and saying some things to your counselor. You can just play with your toys and don't have to pay attention to me. I'd like you to always listen to your counselor and remember that she (or he) is in charge. I'm glad you're both here and you (camper) can look at the toys while I talk to the counselor.

The trainer and counselor should sit to the side of the play area where they can discuss the homework without the camper overhearing. "How did the homework go yesterday? Can I see your homework sheet, please?" At this point, trainers should look at the homework sheet to ensure that counselors completed the homework. Thank the counselors for bringing in the completed sheet and reinforce that the homework will be helpful for them in developing the CCIT skills. Trainers should find out how the homework went and ask counselors if they had

any problems or questions and observe any notes the counselor had. Trainers should try to answer any questions from the counselors and address any issues.

If counselors have not completed the homework sheet, trainers should ask them if they did the homework. If they have done it, then trainers can fill in the homework sheet with the counselors. If counselors have not done the homework, then trainers should ask them why they haven't done it. Trainers should then work with counselors to plan how they can address these issues so they can complete the homework. For example, counselors might say that they were not able to arrange coverage with the other counselors so they could do their special playtime. Trainers should then ask counselors how they could solve the specified issue, in this case lack of coverage, so coverage could be arranged. Trainers can offer suggestions, such as by asking other counselors earlier or getting campers involved in an attention-consuming activity for the other counselors, if counselors can't think of anything.

Coding

Trainers will now begin the 5-minute coding session with the counselor and camper. Trainers will communicate with the counselor via the microphone and the earpiece, which counselors will be wearing in their ears. Counselors and campers should seat themselves adjacent to each other so they can play together. Trainers should sit to the side of the dyad so they are unobtrusive, but can still see the play. Trainers should sit far enough away so that the camper cannot hear the feedback. Trainers will be able to hear the dyad playing and making comments through the counselor's microphone and the counselor will be able to hear the trainer's comments through the earpiece he or she is wearing.

During this time, trainers will use the CCIT-DCICS coding form and code counselors in their use of the PRIDE skills. Trainers will first tell counselors what will happen during coding, then instruct them to begin the session, then observe and code them for 5 minutes, and finally report the results. Trainers will tell counselors:

> We will now begin the 5-minute coding session. During this time, I will record all instances in which you use the PRIDE skills. Try to use all of the PRIDE skills like we've been practicing. Your goals are to try to use ten labeled praises, ten reflections, ten descriptions, (for counselors working with older campers, these goals are seven of each behavior) and to try to have less than three total commands, questions, or criticisms. I will let you know when the 5 minutes is over. To begin, tell the camper (trainers wait for counselors to repeat each sentence), "We will now begin special playtime. The first rule for special playtime is to play nice. The second rule is that whatever falls on the floor stays on the floor. The third rule is to stay in your seat." Okay, I will begin coding and you should try to use as many PRIDE skills as you can.

After the 5 minutes has finished, the trainer should quickly tally the totals in the rows for Praises, Reflections, and Descriptions, tell the counselor to stop the coding session, and report the results to the counselor. In categories in which the counselor met target goals, the trainer should praise the counselor. In categories in which the counselor was below target goals, the trainer should remind the counselor what the target goal was and provide feedback about how the counselor could have done more of those behaviors. An example of how a trainer might give feedback to a counselor is as follows:

> Stop. Alright, you did a great job during coding. You had 11 labeled praises, which meets the goal of ten labeled praises, so you did a great job giving praises. you had 12 reflections, which also is above your goal of ten reflections. (Camper's Name) really liked when you reflected what he said. Also, you only had two questions, comments, or criticisms, which meets the target goal because it is less than three. You had a couple of times where your voice rose up high as if you were asking a question, so those were counted as questions. Try to keep your voice flat in tone. Finally, you had eight descriptions. Your goal was ten, so you were really close. During the coaching session next, I'd like to really concentrate on practicing descriptions. An example of how you might have had more during the coding session was when (camper's name) was building the house with the blocks. You did great saying that he (or she) was doing that, but you

could have described what he was doing in more detail, like, "You picked up the red block. Now, you're looking to see where it goes. You are trying to fit it on the blue block. Now you're trying another block." You can see that by describing everything the camper was doing in small detail I had four description statements. More importantly, the camper would feel like he was the center of the play, and was also learning to connect his actions with words. Now we will begin the coaching session.

As was illustrated, the feedback to the counselor should focus on reinforcing the PRIDE skills she performed well and providing feedback, about how she could meet the goals for the PRIDE skills in which she did not meet the goals. Examples of how he could have used more of those skills in the preceding coding session should be provided. Finally, those skills should be a main focus of the coaching session, which should be communicated to the counselor, although the other PRIDE skills should continue to be utilized and responded to during coaching as well.

Coaching

Now the coaching session will begin. The trainer should give a brief overview of what the coaching will be like. The trainer can say, "We will now begin the coaching. During this time I'll be giving you feedback on how to best use the PRIDE skills. You should continue trying to use them as often as you can."

The trainer will then begin the coaching, giving feedback to the counselor about how to best use the PRIDE skills. This coaching is very similar to coaching that trainers give to parents as PCIT therapists. This coaching session will last 10 to 15 minutes. Trainers should work to provide feedback to ensure counselors are using PRIDE skills at a pace that would allow them to meet target goals in their next coding session.

Trainers should strive to provide feedback about each comment a counselor makes, at least early in the session. If the counselor uses one of the PRIDE skills, the trainer should use a labeled praise to reinforce this behavior. This reinforces using praises for the counselor through vicarious learning. Another way to reinforce the use of the PRIDE skills is through description. By stating the effect the use of the PRIDE skills have on the camper, the counselor will be encouraged. Trainers can say something like, "(Camper's name) really lights up when you tell her (or him) what a great job she's doing playing with the toys."

Trainers should also supply counselors with examples of PRIDE skills that they can use at different times. For example, trainers could encourage counselors to reflect statements that the campers make by repeating the campers' statements for the counselors, using enthusiasm. Counselors should then be encouraged to repeat what the trainer said, resulting in the counselor reflecting the camper's original statement. It may be necessary one time for trainers to instruct counselors to repeat what they say to the camper, but then typically counselors will know to repeat trainer statements to campers, without having to directly be told to do so. It is also typically helpful for trainers to verbalize comments they want the counselors to repeat to campers with a "repeat-after-me" voice, demonstrated the first time they instruct counselors to repeat what they say.

As the trainer is present during the coaching, his or her presence may initially be awkward for all parties and somewhat distracting for the camper. It is typically effective to use ignoring if the camper addresses the trainer. This also models the use of ignoring for the counselor.

Related to the possibility of the trainer's presence being a distraction to the camper is the possibility of undermining the counselor. Because counselors will continue to work with the campers outside of CCIT sessions, it is important for trainers not to subvert the counselors' authority by demeaning their skills or taking control. One effort that can be made to help retain counselors' authority is to try to wait for counselors to use the PRIDE skills and then praise them, especially initially. Another thing trainers can do is to avoid negative feedback in front of the campers. Trainers should first try to reframe a negative behavior by the counselor, such as the use of a Don't Behavior, by first offering an alternative way of saying it, consonant with the PRIDE skills. For example, if a counselor makes a statement with rising intonation at the end, sounding like a question, trainers can state the same statement without rising intonation. If trainers are unable to reframe a negative behavior by the counselors and this behavior continues, trainers should make a note to discuss this with counselors after special playtime, without the presence of the camper.

Concluding Individual Coaching Sessions

At the end of the coaching period, trainers should announce when there are 3 minutes left. They should advise the counselor to notify the camper. This skill of announcing transitions is good for counselors to use, as it helps campers to know what to expect and so they can prepare to finish. Trainers can say to counselors, "Let (camper's name) know, 'In 3 minutes we will be finishing special playtime. I will put the toys away then. You can help me if you'd like.'" It is important that counselors do not state this as a command, as there are no commands in CDI. However, campers are presented with the option of helping counselors, and should be praised if

they do. Counselors will then be informed that they will transition back to the group activity at this time. Counselors will be reminded that they should complete homework, as they were asked to do in the previous session, before the next session. Counselors should be reminded when their next session will be:

> Great job practicing your PRIDE skills today. Your homework will be to have a special playtime session again, as you did before this session. You'll set-up the special playtime session, just as you did before. First, please decide a time that you will be able to have special playtime and a camper with whom you can have special playtime, both of which I'd like you to indicate on your homework sheet. Remember that the total time for setting up materials, conducting the special playtime, and then transitioning back to activities will be up to 20 minutes. During special playtime you should try to use as many of the PRIDE skills as you can, while avoiding using the Don't Behaviors. Please note any relevant information about the special playtime on the homework sheet and bring it to the next session.
>
> In addition, if mastery was not met for a particular PRIDE skill during the coding session, that skill should be identified as a skill upon which to especially focus during homework. This skill should be written in the designated area in the homework sheet. Counselors should be told: "Just like we worked on (specific PRIDE skill) during Coaching today, I'd also like you to especially focus on this skill during homework. Try to use this skill as often as you can. By focusing on this skill, you can hopefully meet mastery criteria in all skills next session. However, also continue to use the other skills as well."

Planning In Situ Coaching Session

Trainers should meet with counselors to discuss the next coaching session, which will be done during a typical camp activity. This activity will have been chosen with the camp administrators and will be an activity in which counselors can easily engage in CDI with the campers, such as an art activity. Trainers will inform counselors about the structure of the session and how the session will proceed. Trainers should say:

> Next session will be a CDI coaching session, as we did today. However, the session will take place during a typical camp activity. This is so you can practice using the skills in situations like those you would typically encounter at camp. The activity that this

coaching session will take place at is (activity that had been previously decided with administrators). The session will begin with you or one of the other counselors introducing me to the group. I will tell the campers about the session and will ask them to ignore me and proceed with the activity as they typically would.

After the introduction, we will begin the session. I will work with each of you individually. I will first hand you a cleaned earpiece. We will then begin a 5-minute coding session. Remember, the goal during the coding session is to use the PRIDE skills as often as you can. You can focus on one camper or multiple campers.

After the 5 minutes of coding, I will announce to you that the coding is finished and we will then begin the coaching session. During this time I will give you feedback about your use of the PRIDE skills. You should continue trying to use the PRIDE skills as often as you can during this time. Are there any questions?

Session 3

In Situ CDI Coaching Session

Session Objectives

- Counselors will increase their understanding of CDI skills by reviewing homework assignments with the trainer.
- Counselors will know how close they are towards their CDI mastery goal, while using CDI skills in camp activities.
- Counselors will improve their use of CDI skills in camp activities through feedback.

Session Outline

1. Trainers will review homework with counselors, and address questions or concerns.
2. Trainers will code counselors in their use of CDI skills in camp activities.
3. Trainers will coach counselors in CDI skills in camp activities.
4. Homework is assigned/Next session planned.

Session Materials

1. CCIT manual;
2. CDI Special Playtime Homework Sheet (Appendix F); and
3. CCIT DCICS coding sheet (Appendix G).

Session Preparation

Prior to the session, trainers should ensure that counselors are expecting the trainers. Trainers will have already informed the counselors that they will be coming to their activity and will be conducting coaching. Trainers should arrange to meet with counselors without campers for about 10 minutes before the coaching session. Trainers should check homework as they did before the last coaching session.

Trainers can now further question counselors about how well the homework is helping them further refine skills. Questions that trainers should likely ask counselors are:

- "Are the skills beginning to feel more natural?"
- "Are you beginning to use the skills at other times of day?"
- "Have you noticed changes in campers' behavior?"

These questions are designed to encourage the counselors to use the skills outside of special playtime and also be aware of the effect of the skills on campers. In addition, when counselors feel that their training results in camper improvement, they are more likely to be motivated to continue to use the skills and fully participate in training.

When trainers arrive at the designated area at which they will conduct the session, they will introduce themselves to the campers and counselors involved in the activity. They should say:

> Hello, I've met many of you already. For those of you whom I haven't met yet, my name is (trainer's name). I will be watching your activity today and saying some things to the counselor while they are doing the activity with you. You can pretend I'm not here and do your activity as you would without me. You should listen to your counselor as you normally should.

Trainers will then begin the coding and coaching session. They will give a cleaned earpiece to a counselor. Trainers should be sensitive to choose the order of counselors by their availability. If a counselor is handling a situation with a camper, it would be best to choose another counselor. The trainer should situate himself so that he is nearby one counselor. This counselor should have at least one camper nearby with whom he can practice using PRIDE skills. However the counselor will not be restricted to using the PRIDE skills with only one camper. It will not be necessary for the counselor and a camper to move to a space away from the group, but the counselor should be allowed to practice the skills freely, without interfering with the activity or being disrupted.

Coding

Trainers will now begin the 5-minute coding session with the chosen counselor. Trainers should provide the counselor with the earpiece and microphone radio. During this time, trainers will use the CCIT-DCICS coding form and code counselors in their use of the PRIDE skills. Trainers will first tell counselors what will happen during coding, then instruct them to begin using PRIDE skills to begin the session, observe and code them for 5 minutes, and finally report the results. Trainers will tell counselors:

> We will now begin the 5-minute coding session. During this time I will record all instances in which you use the PRIDE skills. Try to use all of the PRIDE skills like we've been practicing. Your goals are to try to use ten labeled praises, ten reflections, ten descriptions (seven each for counselors working with older campers), and to try to have less than three total commands, questions, or criticisms. I will let you know when the 5 minutes is over. OK, I will begin coding and you should try to use as many PRIDE skills as you can.

As in the previous coding session, after the 5 minutes has finished, the trainer should quickly tally the totals in the rows for praises, reflections, and descriptions, tell the counselor the coding is finished, and report the results to the counselor. For categories in which the counselor met target goals, the trainer should praise the counselor. For categories in which the counselor was below target goals, the trainer should remind the counselor what the target goal was and provide feedback about how the counselor could have done more of those behaviors.

As in the previous session, the feedback to counselors should focus on reinforcing the PRIDE skills they performed well and providing feedback about how they could meet the goals for the PRIDE skills for which they did not meet the goals. Examples of how the counselors could have used more of those skills in the preceding coding session should be provided. Finally, those skills for which mastery goals were not met should be one of the main focuses of the coaching session, which should be communicated to the counselor; however, the other PRIDE skills should continue to be utilized and responded to during coaching as well. Trainers will then announce, "Now we will begin the coaching session."

Coaching

Now the coaching session will begin. The trainer should announce to the counselor, "We will now begin the coaching. During this time I'll be giving you feedback on how to best use the PRIDE skills. You should continue trying to use them as often as you can." The trainer will then begin the coaching, giving feedback to the counselor about how to best use the PRIDE skills, as in the previous coaching session. This coaching session will last 10 to 15 minutes.

Trainers should work to provide feedback to ensure counselors are using PRIDE skills at a pace that would allow them to meet target goals within their next coding session.

Concluding Individual Coaching Sessions

At the end of the coaching session, trainers should inform counselors that the coaching is over. They should then get the earpiece back from the counselor, clean it, and give to the next counselor. The coding and coaching sequence, as described above, should then proceed for the next counselor, and continue until all counselors have been coded and coached.

After all the counselors have been coded and coached, trainers should briefly meet with counselors. Counselors should be reminded when their next session will be. Trainers should let counselors know that this was the end of the CDI phase and that they will be beginning the CODI phase next session, for which they will meet without campers for an initial training session, during a time of day previously agreed upon with administrators.

Homework

At this point trainers should discuss the homework that they'd like the counselors to do before their next meeting. This homework will be similar to the previous homework, except, as was consistent with this session, that it will have a greater focus on using the PRIDE skills in a more natural setting. Trainers should instruct counselors on how the homework sessions will be conducted and what is expected to happen during this time:

> I'd like you to practice the CDI skills that we covered today, in a natural practice session in a natural setting before we meet next time. This homework will be similar to the homework you completed for today, but will take place during a typical activity, rather than creating your own activity like in the previous homework. This is so that you can

start using the PRIDE skills in typical camp situations and activities. In addition, this natural practice session will be conducted with two campers, so that you can begin to practice using the skills with more than one camper.

It is important to first identify an activity period in which it will be possible to conduct this natural practice session. The activity should allow you to play with the campers in a way such that the campers can lead the play, so an organized activity, like sports, would not be a good activity for this homework. Activities such as art, game time in which you can play relatively unorganized games, or other creative activities would be good to choose.

Second, you should ask two campers to do this activity who are different than the camper with whom you did the last homework. This is so you can practice using the PRIDE skills with a variety of campers. You should indicate the activity where you will do the natural practice session and the campers with whom you will do it on the CDI special playtime sheet. It will be good to schedule the homework at times when other counselors are not doing their homework, so that they can deal with any issues that come up, without disturbing your natural practice session. You should also notify your fellow counselors of when you will have your natural practice session so that they can be aware of when it is occurring so that they can support you. You should note to yourself when the natural practice session is beginning, but then continue the activity in which the campers are involved. So, if the activity is an art project to paint a picture of camp, you can sit next to the campers with whom you are working and focus on using the PRIDE skills with them. You can have a number of crayons, paper, and other art materials and the campers can choose to work on the art project how they want.

As before, note when the 5 minutes has finished. You do not need to announce to the campers that you are conducting the natural practice session or that it has finished. Just practice using the PRIDE skills during this time at a rate that you have been using them during the Coaching sessions. Record that you have completed the natural practice session on this sheet and note any significant events you observed, such as if the camper responded well, if you had problems using one of the PRIDE skills, or anything else that occurred or about which you had questions. Do you have any questions about how to do the homework?

Session 4

Counselor-Directed Intervention (CODI) Instruction

Session Objectives

- Counselors will understand CODI phase goals and the purpose of CODI.
- Counselors will learn how to give effective commands.
- Counselors will learn the CCIT time-out procedure.
- Counselors will have practiced all the CODI procedures.

Session Outline

1. Homework will be reviewed and questions and concerns addressed.
2. Trainers will instruct counselors in how to give effective commands.
3. Trainers will teach the CCIT time-out procedure.
4. Counselors will practice these skills in role-plays.
5. CODI Homework will be assigned.

Session Materials

1. CCIT manual;
2. Effective Commands Handout (Appendix H);
3. CODI Procedure Handout (Appendix I);
4. CODI Complete Blanks Activity Handout (Appendix J); and
5. CDI Homework Sheet (Appendix F).

Session Explanation

Trainers will have already arranged beforehand with administrators how counselors can provide coverage for the campers so that groups of approximately six counselors can attend CODI training. Perhaps one group of counselors will monitor the campers from their own group and another counselors' group during a more likely low-key activity. This will allow the counselors whose campers are being monitored to attend training. The counselors can then switch so that the remaining counselors can attend training.

First of all, trainers should review homework with the counselors. This can be done in a group so that members can benefit from discussing the homework together, possibly with counselors providing suggestions for how to negotiate issues other members encountered during homework. Trainers should facilitate the group discussion, encouraging counselors to provide input, while monitoring that information from group members adheres to CCIT protocol.

To begin training, trainers should first congratulate the counselors on having completed CDI and introduce CODI. Trainers should say:

> Congratulations on having completed CDI. You did a great job using the PRIDE skills. Now we will begin the CODI phase of training. Today we will provide instruction on CODI and practice the skills in role plays. In two later sessions we will practice the techniques with campers, much as we did in CDI. It is important that the procedure we outline in training today is followed correctly.

Trainers will then explain what CODI is:

> CODI is a system for effectively managing camper behavior. You will be taught what to do when campers do not follow directions. As a result, you will only use the CODI skills when campers don't follow directions. You will continue to use the PRIDE skills and other skills you learned in CDI throughout the day with the campers. Because you have learned these skills so well, they will help you to use CODI.

Trainers will then teach what effective commands are as these commands begin the process of using CODI. "CODI begins with the counselor giving a command. We will now talk about what effective commands are. Effective commands are important because campers are more likely to follow effective commands." Effective types of commands are originally described in the PCIT Manual (Hembree-Kigin & McNeil, 2010). However, for the purposes of CCIT, the qualities of effective commands and the way they are instructed have been slightly modified.

Direct Commands

Commands should be direct, not indirect. Direct commands are phrased as directions and are directed towards the camper:

> First of all, commands should be direct, rather than indirect. Direct commands state the direction, rather than ask a question. For example, a direct command is, "Please put the toy in the box," rather than, "Would you like to put the toy in the box?" In the direct command example, the statement is stated as a direction. In the second example, the statement is stated as a question.
>
> Direct commands also are directed towards the child. For example, a direct command is, "Put the piece down," rather than, "Let's put the piece down." In the first example, it is clear that you are asking the camper to put the piece down. In the second example, you are addressing the command to both of you. How might you change these indirect commands to direct commands?

Trainers should ensure counselors correctly change the following indirect commands to direct commands or provide the correct answer when it is not given.

(Indirect) "Why don't you play with this toy?" (Direct) "Please play with this toy."

(Indirect) "How about if you pick it up now?" (Direct) "Please pick up now."

(Indirect) "We should keep the toys on the table." (Direct) "Keep the toys on the table."

Commands Should Be Phrased in Positive Form

Commands should tell the camper what to do, not what to not do. Therefore, commands should be stated in the affirmative. Trainers should tell counselors:

> The next rule of effective commands is that commands should be stated in the positive, that is, telling the camper what to do, rather than telling the camper what not to do. For example, "Don't yell," tells campers what they shouldn't be doing, while "Please be quiet," tells campers what they should be doing. Thus, "Please by quiet," is a more effective command. It is important to use positive commands so that campers know what is expected of them.
>
> Also, a negative command can often sound like criticism to the camper, which we learned in CDI is a behavior to avoid. Often, a positive command can be formed from a negative command by stating the opposite of what you would like the camper to stop doing. So, if you would like the camper to stop running around, the opposite of running around is to sit down. For these next examples, see if you can tell me if the command is positive or negative. If the command is negative, restate it as a positive command.

Trainers should read the following statements and counselors should attempt to identify if they are positive or negative commands, and change the negative commands to positive commands. Trainers should ensure that counselors give the correct answer or supply it if it isn't given.

"Don't sit in that seat." (Negative: "Sit in this seat.")

"Put the rock down." (Positive)

"Stop getting up." (Negative: "Stay seated.")

Commands Should Only Be One Step at a Time

Trainers should instruct the counselors that giving one-step directions is more appropriate for children and easier for them to follow:

> Commands which are multi-directional are hard for children to remember and follow. Therefore, commands which have only one direction at a time are easier for campers to follow. Multi-part commands are two or more directions together, such as, "Get the toys from the box and start building a house." Another type of multi-part command consists of giving a direction for a complicated task that would require multiple steps to get through, like "Clean up the table." The solution for multi-part tasks is to break each task into simple steps that are given one at a time, each given after the camper completes the previous step. For example, we can take that last multi-part command and break it into steps, so each would be an appropriate command. I'd like each person to give a step in that large task of "Clean up the table" that could be said to a camper.

Trainers should ensure that each counselor gives a single step direction. Examples of this could be:

1. "It's time to clean up."
2. "First, take your house apart."
3. "Next, put the pieces in the bag."
4. "Now, separate these toys into groups."
5. "Put the separate groups in their boxes."
6. "Close the bag."

Commands Should Describe the Expectation Specifically

Trainers should explain that unspecific commands don't accurately convey the expectation of counselors:

> Also, commands should be specific. It is difficult for a camper to understand what is expected with a command like, "Behave." It is important to tell the camper the specific action he must take to behave. A better way to phrase that would be, "Sit down in your seat."

Commands Should be Appropriate to the Camper's Level of Understanding

Trainers should instruct counselors to use appropriate language based on campers' developmental levels:

> Language that the camper can understand should be used when giving commands. If the campers are young and/or have issues (if the campers have specific issues at a particular camp that would make understanding complex language difficult the trainer can specify these issues here) that make understanding complicated language difficult, then it is best to use short and direct words to convey meaning. Putting together the ideas that commands should be specific and developmentally appropriate, see if you can change these commands to be specific and developmentally appropriate for the age group with whom you will be primarily working.

Trainers should then read the following statements and get counselors to come up with two or three appropriate commands for each.

Inappropriate and Vague	Specific and Appropriate Commands
"Be appropriate."	Say, "I don't like it." (Instead of swearing)
	"Use words that aren't swear words."
	"Say how you feel about it."
"Be a gentleman."	"Sit up in your chair."
	"Use a quiet voice."

Give Commands in a Calm,
Neutral Tone of Voice

Trainers should explain that commands should be given in a calm voice and explain the reasons for doing so:

> Give commands in a calm tone of voice. Use a tone that is conversational-level in volume, has neutral emotion, and is not critical. The reason for using a calm voice is that it teaches the campers to listen to what you say at any time, not just when you are using a stern voice. Using a stern voice can often induce compliance in campers, but then they will only listen when you are using the stern voice. This also makes it harder for other people who use calm voices to work with the camper. On the other hand, it is important to give commands with confidence to show you mean what you say.

Give Explanations After the Command Has Been
Obeyed or Before the Command is Given

Instruct counselors on giving the explanation either after the command has been obeyed or before the command is given and explain the effect of giving an explanation after the command:

> It can be a good idea to explain the reason we are giving a particular command. This can help the camper connect reasons with actions. However, it is important to give the explanation before the command is given or after the camper has performed the command. For example, you could give an explanation before the command by saying, "Special playtime is almost over. Please put your blocks in the box." That could help the camper understand why it is time to clean up. Also, you could give the explanation after the camper has cleaned up and say, "Thank you for cleaning up so quick. That will help us get to the art activity on time."
>
> However, you should not give the explanation between when the camper is given the command and when she complies. If you give reasons at this time, the camper will likely begin to expect a reason every time you give a command. This will likely result in the camper asking, "Why?" or whining every time you give him a command. In addition, providing a reason after a command could distract the camper from what the original command was.
>
> Trainers will now provide some scenarios in which counselors will practice giving a reason either before the command or after their partner has completed the task. Trainers will

give a scenario and a counselor, acting as a camper, will practice this skill while other counselors watch:

> Now I'd like you to practice giving a reason. You can give the reason before the command or after your partner, who will be playing the camper, has completed the task. However, be sure to not give the explanation between the command and compliance. Here are some scenarios.

Scenarios	Possible Explanations
Clean up.	It helps the bunk look clean.
	It helps us have longer playtime.
Put the toy on the table.	The toy could fall and break.
	The toy might get stepped on.
Give me the toy.	I can put it away.
	We need to clean up fast.

Give Commands Only When Necessary

> It is important to continue to rely on the skills you developed in CDI. As you saw, those skills help the campers to stay on task and create a pleasurable experience for the campers. Although commands are necessary, it is important to use them only when they are necessary and not excessively. When you give a command you must be prepared to follow through using the sequence of discipline in CODI that we will learn. It is important that this sequence be repeated consistently every time. So, if you give a command you should be prepared to follow through.

For Counselors Working with Campers 8-years-old and Older

Counselors working with older campers should follow the same rules for giving commands as specified above, with a slight modification. Whereas with younger campers it is

desirable to give short and frequent commands, older campers can typically understand more complicated commands with multiple steps. Therefore, older campers would likely find short and frequent commands overbearing. However, it is important for counselors to consider the developmental level of each camper and to give campers instructions in accordance with how much information they can process.

> For those of you working with campers age 8 and above, the procedure for giving effective commands is the same, with a slight modification. Whereas with younger campers, you should give short and frequent commands, with older campers you can give longer commands, with multiple steps. This is because older campers can typically process these more complicated instructions and would feel bothered by the shorter more frequent commands. For example, with younger campers you might say, "Take those blocks apart. Put that block in this bag. Put the bag in the box," to direct them to clean up a game. With older campers, you might be able to say, "Clean up the blocks," because they understand all the steps involved with cleaning up the game. However, care must be given to give developmentally appropriate commands to campers. Some campers who are older may still not be able to process compound commands, such as the previous one. Therefore, it is better to start giving smaller commands and proceed to giving more complicated ones.

(End of section for counselors working with campers 8 years old and older.)

Reaction to Command

Trainers should explain to counselors that how the campers respond to a command will determine the counselors' next step. Counselors should focus on the campers' response to the command to determine if the campers comply with the command or disobey.

> Now that you have given a command, you have started a sequence of events with different choices and outcomes. The first step is to determine if the camper is following your command or isn't following your command. The camper might follow your command immediately. On the other hand, she might wait for a few seconds. It is important to give her an opportunity to follow the command, so if she immediately does not follow the command, wait 5 seconds. During this 5 seconds, he might whine or ask why he needs to follow the command. It is important during this time to remain silent and wait for her to react to the command.

We talked before about not explaining reasons for giving commands after they have been given. The same logic applies here. If you explain your reason for giving the command, repeat the command, or raise your voice the camper will learn that she doesn't have to follow directions immediately, but only when you give a reason, repeat the command, or raise your voice, for example. If the camper follows the command within the 5-second period of time she is considered to be following the command. If after you have counted 5 seconds, he still has not followed the command, he is considered to be disobeying the command.

Following the Command

Trainers should explain what counselors should do if the camper follows the command:

If the camper has followed the command within 5 seconds of your having given it, then you will respond with a labeled praise. When giving this labeled praise, however, you should connect your praise to the camper having followed your directions. For example, you could say, "Great job following my directions," or "Good job doing what I asked." This shows the camper that you are praising her for her compliance and will encourage her to follow your directions again.

For Counselors Working with Campers 8-years-old and Older

It is important for counselors working with older campers to give praise that sounds genuine. Older campers would likely feel invalidated by praise which sounds rote or patronizing. Therefore, it is important to give praise which sounds age-appropriate and meaningful:

For those of you working with older campers, you should give praise which is age-appropriate and sounds like you really mean the praise. Older campers can more easily recognize an adult's true feeling about their actions. They will likely only feel motivated to follow commands when a counselor is genuinely proud of their action. Thus, rote and mechanical praises, such as using the same praise for each accomplishment, such as "Thank you for following my directions," will not be motivating to the older camper. Therefore, try to use different praises. In addition, non-verbal and unlabeled praises are acceptable if they seem to convey more genuine appreciation. An example of this might be, "Way to go! Give me a high-five."

(End of section for counselors working with campers 8-years-old and older.)

Disobeying the Command

Trainers will explain the procedure counselors should follow if the camper does not comply with the command. It will be important to have discussed what will be appropriate time-out areas with administrators before camp has begun as this will be the area counselors will assign campers who do not comply with directions. This time-out area might be a bench outside activity areas or a space in the bunks, for example.

> If after you have given a command and waited 5 seconds and the camper still has not complied with your command, you should begin the time-out procedure. This procedure begins with a warning. The wording you use should be the same every time and the same across all counselors. This ensures consistency within and across counselors which helps campers learn the procedure. You should say, "If you don't (command), you will have to go to the (time-out area)." For example, if the command is to give you the toy and the time-out area is the bench outside of the art area, you will say, "If you choose not to give the toy to me, then you have to go to the bench." At this point, you will again give the camper a 5-second opportunity to respond to your command, just as with the original command. It would be best if campers follow directions on the first command, but some of the campers are still learning to follow directions, so this warning gives them one more chance to do so. Again, you will evaluate whether or not the campers comply with your warning.

Camper Follows Directions

Trainers will instruct counselors to respond with labeled praise if the camper complies with the counselor's warning. Trainers will also explain that they should only praise and not criticize that campers did not respond on the initial request, as the praise is designed to positively reinforce campers, while criticism might deter future compliance.

> Just as when you gave the initial command and the camper followed directions, if the camper follows directions after the warning, you will give a labeled praise. Again, you should connect this praise to the camper following your directions. It is important to only give the labeled praise and not criticize, as your praise will help reinforce campers following directions, while criticism might make them not want to follow directions.

Camper Doesn't Follow Directions in Warning

Trainers should instruct counselors to begin the timeout procedure if campers do not follow directions after a warning has been given. Counselors will direct campers to the timeout area. Campers may choose not to go to the timeout area. Counselors are not allowed to put hands on campers unless they are being unsafe, so counselors should not force the campers to go to the timeout area. Rather, counselors should restate the expectation, which is that campers are not allowed to return to the activity until they have gone to the timeout area. For continued noncompliance, counselors should remind campers that the sooner they go to the timeout area the sooner they will return to activities. Counselors should also be advised that if campers begin being unsafe during this time that they should initiate their procedures for handling unsafe camper behavior.

> If the camper has not complied with your command 5 seconds after the warning has been given, you should begin the timeout procedure. It is important to follow the timeout procedure closely, using the words that are specified, so that the timeout will be given safely and effectively. You should tell the camper, "You didn't do what I told you, so you have to go to (designated time-out area)." This makes it very clear to the camper what is expected and because all counselors will be saying it, the camper will learn to understand what is expected." At this point, the camper might comply and go to the time-out chair or he may continue to not follow directions. There are ways to handle both choices. However, counselors should not force campers to go to the timeout area. Counselors are not allowed to put hands on children unless they are being unsafe. If, however, at any time during the timeout procedure, or during other times for that matter, the camper is being unsafe you should follow your (state unsafe behavior intervention training).

Camper Time-Out Defined

Trainers should define what constitutes a time-out. Campers should be sitting in the time-out area, with at least some of their body touching the time-out chair or designated sitting area. Trainers should instruct counselors what to do when campers are not taking their time-out properly, with the goal being that counselors explain to campers what the time-out procedure is only one time, so that campers are able to be compliant with the timeout and then re-enter programming.

> It is important to define what constitutes a time-out. The camper should be sitting in the designated time-out area with at least some part of his or her body in the time-out seat or designated sitting area (trainers should name what they and administrators decided are areas for campers to take timeouts). Campers may intentionally try to provoke a reaction from counselors by pushing the boundaries of what is acceptable time-out behavior. In addition, many campers have issues which make sitting still in one place for an extended period of time challenging. Therefore, mild camper movement or noise can be tolerated.
>
> The point of the time-out is to give campers a chance to reflect on what they did to get the time-out and what could be done better, to provide a consequence for non-compliant behavior, and to give counselors and campers a chance to defuse what could be a potentially stressful encounter. If the camper moves excessively, doesn't remain sitting, or is excessively loud, the counselor should explain to the camper what is expected from her in time-out. The counselor should say, "You (inappropriate time-out behavior). You need to sit here quietly until I tell you that you can leave." So, if the camper is getting out of her time-out seat, you should say, "You got out of your seat. You need to sit here quietly until I tell you that you can leave." The time-out will then re-start at that time. This warning should only be given once to a camper. It is given once so that the camper is clear about what is expected in time-out. It is not given again because then the camper might behave negatively in time-out to get the attention of the counselor, by having him repeat the warning.

Camper Doesn't Follow Time-Out Procedure

Trainers should instruct counselors in how to handle campers who refuse to go to the time-out area. The goal is not to give the camper attention while he is not following directions. If campers do not comply with the direction to sit in the timeout area, the counselor should state

that the camper must sit in the time-out area to return to activities. After counselors have stated the expectation that campers should sit in the timeout area, they should return their focus to the rest of the group, while still monitoring the camper for safety. Counselors should repeat the expectation for campers to sit in the time-out area about every 5 minutes.

> The camper might refuse to sit in the time-out area. That can be frustrating, because it can feel like you don't have any power, but in fact you control when the camper can return to the group activity, which can be a big incentive for campers. So if the camper does not go to the time-out area say to her, "After you sit in the time-out area, you can return to activity." Do not state the amount of time that the camper will be on timeout. One reason is that sometimes even 5 minutes can seem like too long for a child who is escalated. Therefore, focusing on the time can be a further escalation.
>
> Second, it may be necessary to add a couple minutes to the time-out if the camper is especially escalated or takes some time to begin the timeout. Specifying a definitive amount of time for the timeout initially can create a power struggle or further escalate the camper, both situations to avoid by not stating an amount of time initially. If the camper asks how long her time out will be, you can respond that you will answer questions when she is sitting and that the sooner she sits, the sooner the timeout will be over.
>
> If at this time or anytime the camper sits in the time-out area, then begin to follow the procedure for campers following time-out. If the camper still doesn't sit in the time-out area, the goal is to not give her too much attention for his non-compliance. You can direct your attention back to the group activity to indicate that you will give attention to campers who are following directions.
>
> On the other hand, you should still monitor the camper for safety reasons. Often, when campers don't have attention for their non-compliance, they will comply to get back in the activity. On the other hand, a camper might not comply with the time-out direction for some time. If that's the case, just wait until the camper complies. You should restate the direction, "After you sit in the time-out area, you can return to activity" every 5 minutes, as some campers who have difficulty focusing might forget what they are supposed to do. When the camper eventually complies, then move to the procedure for campers following the time-out.

Camper Follows Time-out Procedure

Trainers should instruct counselors to follow the following procedure when the camper sits in the time-out area. Counselors should initiate this sequence whenever the camper sits in the time-out area, whether it is immediately or after a delay.

When the camper sits in the time-out area, you should say the following, "Sit here quietly until I tell you to get up." The counselor should then give a camper 5 minutes to sit in the timeout area. If the camper asks how long they will be sitting in timeout, it is fine to tell them it will be 5 minutes long.

During this time it is important to ignore inappropriate behavior, such as the camper making faces, gesturing inappropriately, or moving around minimally. Many of these behaviors are attempts by the camper to try to engage the counselor in a power struggle. By ignoring this inappropriate behavior, counselors are not reinforcing it and it will likely stop in time.

There may be some limited times when the camper is appropriately trying to engage the counselor and it may be appropriate for the counselor to respond. An example of this might be if a camper is appropriately taking a timeout and asks the counselor how much time is left. It is permissible for a counselor to respond to some appropriate communication from the camper, such as this. However, this communication should be kept to a minimum, as it is important to convey that the camper can engage the counselor when she is making good choices and that she should be considering her behavior after she has made bad choices.

It is important that at the end of 5 minutes the camper is quiet for at least 10 seconds, so wait until she is quiet before stopping the timeout. This shows the camper that the time-out is over because he sat quietly and not because he was being defiant. At the end of the time-out period, ask the camper if she is ready to do the command you had given.

Camper Remains Defiant

If the camper states that she will still not follow directions or if she still appears defiant, such as by not answering the counselor's question to indicate she is ready to comply, you can tell her, "Please let me know when you are ready to follow directions." You should indicate that the camper should remain in the timeout area. Upon the camper indicating he is ready to comply, then follow procedures for what to do if a camper is compliant. If the camper does not indicate she is ready to comply with the time out, you can again ask the camper if she is ready to do the command after another 5 minute timeout, and follow procedures for what to do if a camper is compliant. The goal here is not to punish campers for being angry or to make them absolutely agree with counselors. However, it is important to make sure campers are ready to follow directions, so that another timeout can be avoided.

Processing the Timeout

If you do not wish to process the timeout with the camper, then proceed directly to the next section. If the camper has completed the timeout successfully, it is appropriate to

process the timeout with her. You should follow the (state preferred camp format for processing negative behaviors with campers). On the other hand, you should be mindful that the goal is to return the camper to the activity quickly. In addition, giving the camper excessive individual attention might seem to reward negative behavior. After you have processed the event with the camper, follow the next section "Camper Complies with Command."

Camper Complies with Command

If the camper has stated or in other ways indicated that she is ready to do the command (for example, nonverbally, such as by a head nod), then return the camper to the activity and repeat the original command. If the camper complies with the original command then state another similar command. For example, if you originally stated to give you the toy, then you might state, "Fine, now give me the other toy." You will not give praise to the first command as the camper demonstrated noncompliance, which should not be rewarded with praise. However, you will give the camper a labeled praise for the second new command if he complies. This labeled praise should emphasize the fact that she followed your command quickly. For example, you can say, "Thank you for handing me the toy so quickly. When you follow the directions, we get to play together."

Discussion with Counselors

Trainers should initiate a discussion about CODI with the counselors. It is important that the counselors believe in this intervention in order for them to perform it properly. So it is worthwhile for trainers to answer questions and address concerns that counselors have. These may include questions about the efficacy of the procedure, the compatibility of this procedure with other camp procedures, and possible alterations to the procedure.

These concerns can be addressed with the following responses, respectively. First, this procedure is based on similar researched procedures that have been shown to be effective in reducing children's negative behavior, improving interactions between adults and children, and reducing stress in adults. Second, the procedure is designed to limit infringement into other

camp activities, using a short timeout period for instance, with the goal to get the campers back into programming. Third, there could be a number of possible unexpected variations to the procedure, such as if the camper is squatting in the time-out area, instead of sitting, for example.

To address these possible issues, counselors should remember the purpose of the timeout procedure, which is to encourage camper compliance with commands, to return campers to camp programming quickly, and to administer a safe and consistent timeout procedure. Counselors should be somewhat flexible with the procedure in order to address problems in the implementation of the procedure as they arise. As counselors may initially be reticent in beginning the discussion trainers might initiate conversation by asking some questions, such as ones related to the previously mentioned issues.

Counselors Identify Steps in the CODI Procedure

Trainers should distribute the handout CODI Complete Blanks Activity (Appendix J), which provides a flowchart of the steps involved in the CODI procedure, with blanks for the names or description of each step. Trainers should ask counselors to fill in the blanks. Afterwards, trainers should ask counselors for their answers at each step. Trainers should try to elicit group answers if a counselor is unsure or incorrect about a particular step. At the conclusion of this exercise, trainers should distribute the handout "CODI Steps," which is a flowchart of the steps in CODI. Trainers should encourage counselors to compare their written steps with the supplied steps.

CODI Role Plays

Trainers will now lead counselors in role plays of the steps in CODI. First, co-trainers should demonstrate the CODI process in its entirety with all the steps in the time-out sequence, as described above. One trainer should be the camper and the other should be the counselor. If only one trainer is available, this trainer will pretend to be the counselor and one of the counselors will be assigned the role of camper, with the trainer supplying this counselor with directions of what to do at each step.

First, the trainer role-playing as the counselor should give a command, which the camper should not follow. The trainer will wait 5 seconds and then give a warning, which the camper will again ignore. The trainer will then wait 5 seconds and administer the time-out procedure. The camper will go to the time-out area. The counselor will give the camper directions for staying in time-out. The camper can demonstrate some inappropriate behavior which the counselor will ignore. The camper can then escalate his inappropriate behavior. The counselor will then give the directions for how to behave in time-out. The camper will then complete his time-out. The counselor will ask the camper if she is ready to follow the direction. The counselor can then process what happened with the camper, using the typical procedure espoused by the camp, such as reviewing the process that led up to the time-out.

The counselor will then lead the camper back to the activity and repeat the original command. The camper will follow the command. The counselor will give another command, which the camper will follow. The counselor will then give a labeled praise to the camper for following directions: “We will now perform a role-play illustrating the entire CODI sequence. Recognize all of the steps that you have been taught. We will discuss what you observed

afterwards." After the completion of the role play, trainers should ask counselors to identify each of the steps in the CODI sequence, for example, identifying that the initial command occurred when the counselor gave a command for the camper to give him a toy.

Counselor Role Plays

Trainers should then instruct counselors to perform their own role-plays with a partner, alternating between each partner playing the role of the counselor and the camper. Counselors should use their "CODI Steps" handout to ensure they are following each step of the process. Trainers should instruct counselors to vary the outcomes, so that sometimes the camper reacts differently to each step, such as by not following a time-out. At the conclusions of counselors practicing role-plays, partners will perform role-plays for the other counselors, with these counselors observing and giving feedback about what they saw. The trainers should privately provide the counselor playing the camper role with instructions about how she should behave. Each type of situation should be covered in role-plays, such as having the camper get out of his seat in time-out.

> Now I'd like you all to practice CODI with each other. With a partner, one person will play the counselor and the other will be the camper. The counselor will conduct a special playtime session with the camper, much as you did in CDI. However, you will also be giving commands during this session. You should go through the entire sequence of CODI. Use your CODI Sheets to ensure you are following the process accurately. Counselor playing campers should try to vary the way they react to the commands, sometimes following them and sometimes not following them. Remember to try to follow the steps as accurately as possible, as this will help the campers learn to follow the directions.

After the counselors have practiced role-plays for about 10 minutes, trainers should say:

> Now I would like for counselor pairs to demonstrate role plays while the other counselors watch. The counselors will conduct a special playtime session, while giving commands.

> The counselor playing the camper should respond in the way in which I instruct her. The counselor playing the counselor should respond, using the appropriate CODI steps. As you (the other counselors) watch the role plays, think about how the counselor reacts to these situations and think about any feedback you could give to the counselor about how she used the CODI steps well and how she could use the CODI steps better.
> Trainers should supervise the role-plays to ensure: that counselors perform them

appropriately, that the instructions are followed, and that counselors who are watching provide accurate feedback. Counselors playing counselors should role play as if they were conducting an actual special playtime session. The trainer will assign one of the following variations in private to the counselor playing the camper, so that the counselor playing the counselor doesn't know:

- Follow commands the first two times and then refuse on the third command; follow directions after the warning.
- Ask the reason for the command and don't comply, and then continue asking why she (the camper) has to take a time-out during the time-out.
- Refuse to take a time-out for a few minutes then take one.
- Behave inappropriately during time-out, necessitating a warning; then push the boundaries of acceptability, but generally behave appropriately.
- Refuse to agree to follow the command at the conclusion of the time-out; after a second time-out agree to follow the command, but then refuse to do the command back at the activity.
- Other variations so that each counselor can perform the CODI sequence one time for the other counselors.

Next Steps

Trainers should instruct counselors about what to do next. Counselors should not attempt CODI on their own immediately, as it is important that trainers observe counselors the first time they attempt CODI to ensure it is performed appropriately. Trainers should instruct counselors that they should continue their special playtime with campers until the next session, while practicing their CDI skills. In addition, they should review the CODI handouts and be prepared to begin CODI the next session. Finally, counselors should plan to be coached in the next session with the trainer.

Counselors should complete their CODI Homework/Coaching sheets (Appendix K) with the time for their first CODI coaching session written on the sheet. CODI coaching for the entire group will take place during the same period. Also, counselors should plan with which campers they will participate in CODI coaching and indicate that camper on the sheet. Trainers should inform counselors that sometimes in the coming CODI coaching sessions, it may be necessary to change the scheduled counselor and camper pairings, depending on the camper's behavior. If some campers are following all of the commands, then counselors who are working with them will not get a chance to practice the CODI procedure. Therefore the trainers might deem it necessary to pair these counselors with a camper who has greater difficulty following directions. Trainers will inform counselors if their pairings with campers have been changed at the beginning of their group's scheduled coaching sessions. Thus, trainers should try to ensure that all counselors get to practice CODI at least once.

Trainers should review counselor coaching and homework records after each session. If a counselor has not yet practiced CODI, then the trainer will try to schedule that counselor with a

camper who tends to have more difficulty following commands. The trainer will know who these campers are through the counselor coaching and homework records.

> Good job learning about CODI today. Before the next session you will not practice CODI on your own. The reason is because it is important that CODI be done well the first time, so I will supervise you during your first time. You should, however, continue to do your special playtime homework, practicing your CDI skills as usual. In addition, please review the handouts on giving effective commands and the CODI sequence before next session. Please complete your CODI Homework/Coaching sheet with the time that we will meet with for your first CODI coaching session (trainer announces what period it is) and indicate a camper with whom you would like to practice. The CODI sessions can vary in length, depending on the camper's response to the procedure, so please be flexible with starting times for the sessions.
>
> Also, there may be times that counselors don't get to practice the CODI procedure because the campers with whom they are having coaching sessions or special playtime sessions follow directions. If that is the case it may be necessary to change pairings to pair these counselors with campers who have a more difficult time following directions so that these counselors may practice the CODI skills. If the pairings are changed, you will be notified at the beginning of the sessions for your group.

Session 5

1st Counselor-Directed Intervention (CODI) Coaching

Session Objectives

- Counselors will learn how to give effective commands.
- Counselors will learn the CCIT time-out procedure.

Session Outline

1. Trainers will review homework with counselors and address questions and concerns.
2. Trainers will orient campers to CODI.
3. Trainers will coach counselors in CODI procedures.

Session Materials

1. CCIT manual;
2. Doll or figurine;
3. CODI Homework Handout (Appendix K); and
4. CODI Coding Form (Appendix L).

Session Explanation

Review Homework

To begin the session, trainers should review the special playtime homework, which had been assigned to counselors. Trainers should ensure the counselors completed the homework and answer any questions counselors had. Trainers also requested that counselors review their

sheets on giving effective commands and the CODI sequence. Trainers should review both of these sheets again with counselors, identifying each type of command and each step in the CODI procedure.

Explain How CODI Will Be Practiced In Coaching Sessions

> We will be practicing CODI skills in special playtime. Initially, the commands you will give will be simple, such as, "Put the blocks in the box." We will be practicing the CODI skills in response to campers following through with a request. Campers will begin to learn to follow your commands. Later, we will begin to practice commands that will be more applicable to camp, such as walking to the waterfront.

Explain the CODI Procedure to Campers

Trainers should explain to campers that special playtime will be different in the coming sessions in that counselors will be giving commands to campers. Trainers will also tell campers that the purpose of the counselors giving commands is to help the campers be able to follow directions better. Trainers will demonstrate the procedure with dolls for the campers. Trainers will tell campers:

> Beginning today, we will be doing things a little differently in special playtime. Now (counselor's name) will be giving directions during the playtime. This is so you can practice following directions. Here is an example of how this will look.

Trainers will demonstrate the CODI procedure with a doll playing the part of the counselor. The counselor will be using a doll to play the part of the camper. If the camp has a special mascot or doll that is associated with their camp, these figures can be used at this time. This demonstration will illustrate the CODI steps to the camper so he will know what to expect. It will also help the counselor review the CODI steps one more time. The entire CODI

procedure should be demonstrated to the camper, with each variation listed in the CODI sheet performed.

Trainers Give Counselors Overview of Coaching Procedure

Trainers will now tell counselors how to conduct the CODI coaching. Counselors will begin by using CDI skills. The trainers will then instruct the counselor to give the camper a certain command. The trainers will guide the counselors in how to respond to the campers using CODI procedures. Trainers should emphasize the importance of being accurate with the language and steps that are used and thus the trainers will be giving direct instruction frequently, initially.

> We will now begin the CODI coaching. We will begin with you first using the CDI skills as you had been doing previously. After about 3 minutes, I will instruct you to explain to the camper that we will begin CODI by saying, "I will now be giving you directions. I want you to do what I tell you to do. If you do what I tell you to do, we can keep playing. If you don't do what I ask, you will have to sit in a timeout." You will then give a command and we will begin the CODI process. You will continue to use CDI skills outside of times you are giving commands and responding. Let's get started.

Trainers Coach CDI for 3 Minutes

During this time, trainers will coach CDI as they had done previously. The purpose of beginning with CDI is to begin special playtime as how the camper and counselor are familiar, which will also keep the camper invested in participating.

Begin CODI Coaching

In general, the goal of CODI coaching is to help counselors adhere to the steps outlined in the CODI sheets and to give effective commands. After three minutes of CDI coaching, the trainer will instruct the counselor to give a command, which begins the CODI procedure, although counselors will continue to use CDI skills and be coached in using CDI skills between commands and responses. This command should follow the rules of effective commands. This command may be something like, "Please give me the toy."

Initially, trainers will give frequent and detailed instruction, often before the counselor responds in order that the counselors perform the procedures correctly initially. After counselors have gone through the command and response sequence once with the trainers leading instructions, then counselors should be allowed to respond on their own initiative, with the trainer remaining vigilant to ensure the counselor is performing the procedure correctly. Trainers should provide a labeled praise after every time the counselor gives an effective command and respond with his or her own labeled praise, such as by saying, "Nice direct command," and, "Good job telling the camper, 'Thank you for listening to my directions.'"

Another point for trainers to remember is that there may be a tendency for counselors to attempt to use the CODI procedures, such as by instructing the camper to take a time-out, at any time the camper demonstrates inappropriate behavior. The CODI procedure should initially be used only when a command has been given and in connection with the camper's response to this command. During times in which the camper is behaving negatively, such as by yelling or banging toys, counselors should ignore this behavior, as they had done during CDI sessions. Trainers should encourage ignoring and acknowledge to the counselor when she has done it.

This will help counselors recognize that they are using ignoring as they have done before and should continue to use it.

After CODI Coaching

With a few minutes left in the CODI coaching, trainers should instruct counselors to inform campers that there are only three minutes left and give the camper a command to clean up. After this final command and subsequent response by the counselor (either a labeled praise if the camper cleans up or the CODI process if the camper does not follow the command) concludes, trainers will give counselors instructions on their homework.

CODI Homework

Trainers should give counselors instructions about how to complete the CODI homework. Trainers should inform counselors that they will be using the CODI skills during their special playtime with a camper while they are continuing to practice their CDI skills, much as they did during this CODI coaching session. They should use the CODI homework sheet to record what occurred during the homework, including the commands given and the response to the command, noting the steps that were followed. They will not use CODI outside of special playtime or coaching sessions, as they will focus on performing the steps accurately during special playtime. Trainers should instruct counselors on how to manage camper negative behaviors outside of special playtime. Counselors should continue to ignore camper behavior that is mildly inappropriate, while occasionally having to give commands when camper behavior is more seriously inappropriate.

Good job in the first CODI coaching session. I'd like to tell you about the CODI homework. I'd like you to repeat what we have done in this CODI coaching session during special playtime. Continue to practice using the CDI skills. Use only the CDI skills for the first three minutes of special playtime in order to begin the special playtime on a positive note. After three minutes has passed you will inform the camper that CODI is beginning by saying, "I will now be giving you directions. I want you to do what I tell you to do. If you do what I tell you to do we can keep playing. If you don't do what I ask, you will have to sit in a timeout." These instructions are at the top of your homework sheet as well.

While you are practicing giving commands, follow the rules for effective commands. After you have given a command, follow the CODI procedures in response to the camper's response to the command. You should have this special playtime for about 10 minutes. That will give you enough time to go through the CODI procedures. If you are administering a time-out at the scheduled end of special playtime, you should have at least 2 minutes more of special playtime using only the CDI skills. That will ensure that the special playtime ends on a good note.

As before, you will record your homework on this homework sheet, noting what was done and any concerns you may have. Also on this homework sheet you should record the commands given and the steps that were taken afterwards. For example, if you give the command, "Please hand me the toy," you will record that command in the "Command" column. If the camper doesn't respond, wait 5 seconds, give the warning, and then if he gives you the toy, you will check the boxes labeled "Camper Doesn't Follow Command," "Five Seconds Counted Silently," "Warning Given," and "Camper Follows Warning."

For now, only use the CODI procedure during special playtime. We will practice later using CODI procedures outside of special playtime, but it is important to first practice it accurately during special playtime. When you encounter negative behavior outside of special playtime, try to ignore it as you had previously done in CDI sessions, unless it is behavior that can't be ignored, such as if the camper is being unsafe. If the camper is being unsafe, then you should follow your procedures for handling unsafe behaviors (state procedure).

Finally, during the next session we will be generalizing the CODI procedure to specific areas in which the camper, with whom you'll be practicing CODI with in coaching sessions, has especial difficulty. You'll be selecting the camper you'll be working with at the end of this session. I'd like you to observe your chosen camper throughout the day and note when he seems to struggle with following directions the most. It could be at bedtime or when washing up for meals, for example. I'd like you to write on the homework sheet in what area the camper has difficulty.

Also, I'd like you to write each of the specific steps that are involved in accomplishing that task. For example, if the task is for the camper to brush her teeth, that might involve the camper getting her toothbrush from her bunk, going to the washhouse, applying a pea-sized amount of toothpaste, and brushing her teeth for 30 seconds, among other steps. Writing down each of these steps will help to develop effective commands to guide the camper through this process.

During the next session we will use the CODI skills in a role-play with the camper about that situation. It will be helpful if you can bring in any materials related to that activity. For example, if the camper has difficulty going to brush his teeth for bedtime, bring a toothbrush and toothpaste.

Counselors Not Able to Use Time-out Procedure

There may be occasions that counselors are not able to practice the time-out procedure during CODI coaching sessions because the camper is complying with all commands. This is problematic for the counselor because he is not able to practice the CODI skills. If this occurs, efforts should be made to pair this counselor with a camper who has greater difficulty following directions, so that he may have an opportunity to practice the CODI skills. Trainers should identify counselors who have not practiced the CODI skills after the coaching session or for homework. They should try to identify campers who have greater difficulty than others following directions and pair them with these counselors. This might require that the trainers modify the counselors' plans in terms of the campers that they had initially selected. However, trainers will have informed counselors at the end of CODI instruction, when discussing scheduling that this might be necessary in these conditions. Trainers should inform the counselors at the beginning of the CODI coaching session for their group that the schedule was changed and what the new schedule is.

Session 6

2nd Counselor-Directed Intervention (CODI) Coaching Session

Session Objectives

- Counselors will demonstrate appropriate use of CODI skills.
- Counselors will apply CODI skills to a camp situation.

Session Outline

1. Trainers will review homework with counselors and address questions and concerns.
2. Trainers will code counselors in CODI procedures.
3. Trainers will coach counselors in CODI procedures in a camp situation.
4. Trainers will assign homework.

Session Materials

1. CCIT manual;
2. CODI Homework Handout (Appendix K); and
3. CODI Coding Form (Appendix L).

Session Explanation

Review Homework

At the beginning of this session, trainers should review the first CODI homework in detail with the counselors, using the CODI homework sheet. They should review what commands were given and the steps that were taken in response to the campers' responses to the

commands. Trainers should ensure that the proper procedures were followed based on camper responses. Trainers should also inquire as to if there were any problems in the CODI sequence.

CODI Coding

Trainers will first code counselors in their use of CODI techniques. Trainers will explain to counselors that they will begin by having a special playtime session in which they use the CODI techniques, much as they had done for homework. The counselors will begin with three minutes of using CDI skills. After that time they will continue using CDI skills while then giving commands, which will be followed with the CODI steps, depending on the camper's response.

> We will begin with a coding session in which you will demonstrate your use of the CODI skills, while I observe your use of the skills. Much like with the homework, you will begin with three minutes of using CDI skills only. After that time, I will tell you to begin using CODI skills. You will then give instructions to the camper, as you did in homework, informing him or her that CODI is beginning. You will continue using CDI skills, but in addition will give effective commands and respond using the appropriate CODI procedures. Your goal is to use the CODI procedures appropriately, which consists of giving at least 4 effective commands, using the CODI steps in response with 75% accuracy, and if a time-out is given administering the whole procedure. Okay, we will now begin the coding session.

Trainers will instruct counselors to give the child the directions for beginning special playtime, that is, to play nice, that whatever falls on the floor stays on the floor, and to stay seated. Counselors will practice CDI skills for three minutes. After three minutes, trainers should prompt the counselors to begin CODI and inform the camper that it will begin. Trainers should ensure that counselors instruct campers that CODI will begin by saying, "I will now be giving you directions. I want you to do what I tell you to do. If you do what I tell you to do we can keep playing. If you don't do what I ask, you will have to sit in a timeout."

During the CODI coding session, trainers will code the counselors on their use of the CODI skills, marking the boxes indicating the counselor's use of the skills in response to the camper's behaviors. Trainers should ensure that counselors are using the correct language as they use the CODI skills. At the end of the coding session, trainers should give counselors feedback about their performance and if they met the mastery goals.

Trainers should begin by telling counselor what they did well, for example stating, "You did a great job giving 5 effective commands. That is above the goal of 4." Trainers should then let counselors know what goals they did not meet and what could be done to make improvements in those areas, such as by saying:

> After two commands you didn't wait 5 seconds before giving the warning after the camper didn't respond. Be sure to wait that time so that the camper has a chance to follow the command. Perhaps you can count by thousands to remember to wait the 5 seconds.

Generalizing CODI Skills

Trainers will now work with counselors to use the CODI skills in an area in which the camper has difficulty following commands. Counselors were asked to identify an area in which the camper has difficulty following commands as well as bring in materials necessary to complete tasks in this area to the session. Trainers should ask counselors what area they have identified for the campers. Trainers should ask counselors to describe the situation and what difficulty the camper has in that situation. Trainers should ask counselors what goal they have for the campers during that situations, such as brushing his teeth and going to the bunk for bedtime.

Trainers should then point out the steps that the task consists of that the counselor has identified, which will be used to form effective commands. Trainers should then explain to counselors that they will be practicing the CODI skills in a role-play of that situation with the camper. The counselor should give effective commands to the camper to help him reach the goal the counselor has identified and then use CODI skills in response to the camper's response. Trainers should explain to campers about the role play and what will happen.

> Now we will be applying the skills you have learned to a specific area in which the camper has been having difficulty. Please tell me what area you have identified in which the camper has been having difficulty (trainer guides discussion about this area, eliciting details about the nature of the difficulties, in order to create a realistic role-play). What goal do you have for the camper in this activity? The goal should be specific, so that it can be determined whether or not the camper achieves this goal, as well as achievable for the camper (here the trainer should ensure that the counselor states a clear and specific goal that identifies a behavior that the camper is capable of doing and which can be identified as occurring or not. For example, a goal to brush teeth is clear and it can be determined whether the camper does it or not, while the goal of "get ready for bed" doesn't clearly specify what is expected.) What steps have you identified that the goal consists of? These will be the bases for your effective commands, which you will give the camper.
>
> You and the camper will perform a role-play about the task you have identified. You will be giving the camper commands to guide him or her through the task. You will use the rules of effective commands to give the commands. You will use the CODI skills in response to the camper's response to the commands. I will be coaching you throughout the process.

Explanation to Camper

Trainers and counselors should explain the role play to the camper. They should work with the camper to identify what it is about the task that is difficult for the camper and what could be done to make it easier. The counselor can then incorporate the camper's ideas into the role-play and into the actual situation. Trainers and counselors should emphasize that the role-

play is being done to help the camper succeed so that the camper can be in activities sooner. After the camper has completed the task the counselor and camper will resume playtime.

> Trainer to the camper: "Hi (camper's name). I'd like to talk to you about a situation that I heard you've been having trouble with, (identify situation and begin dialogue with camper about the situation). What do you think about it? What do you think makes this situation hard for you? What could make it easier?"
>
> Based on the camper's response about what makes the situation difficult and what could make it easier, the trainer should then convey to the camper that the trainer and counselor would like to incorporate these ideas into the task. For example, the camper might identify that he doesn't like the taste of the toothpaste and thinks it takes too long to brush his teeth. The trainer could then try to elicit suggestions about how to address these issues. Perhaps the counselor and camper identify that getting some better tasting toothpaste and having a song so that the camper knows how long to brush his teeth could be helpful.
>
> Based on this, the trainer could say the following to the camper, "Thank you for that information. Those sound like great ideas to help you brush your teeth, getting some better tasting toothpaste and having the counselor sing a song while you are brushing.) We'd like to practice (state task) with you. This will help make (state task) easier for you to do in real life and will help you participate in camp activities quicker. After we go through the activity here for pretend, your counselor and you will then get to play together. Just like before when the counselor gave you directions it's important that you follow directions. If you don't follow directions you will have to take a time-out, just like before. We will now start the pretend task.

Trainers will then describe the set-up to the activity for the campers. For example, if the activity is brushing teeth, the trainer will describe that it is nighttime, the campers have just finished their dinner, and they are about to brush their teeth. The trainer will then indicate that the counselor should begin by using the CDI skills, praising the camper for coming back from dinner and describing that the camper has come back into the bunk and sat on the bed, for example. The trainer will then indicate that the counselor should give the first command to the camper, such as, "I want you to get your toothbrush." The counselor should then respond using the appropriate CODI response, based on the camper response.

After the command has been accomplished, the counselor should be sure to give the camper labeled praise. The counselor should then be directed to give the camper the next command on the list. Coaching should proceed in this way until successful completion of the task. While the coaching is occurring, the trainer will be marking the CODI homework/coaching sheet (Appendix K), indicating the outcome of each command. Upon successfully completing the task, the camper should be praised and then there should be a debriefing about what occurred with the counselor and camper. The trainer should emphasize that the camper completed the task and that when this task is done for real later, the process will be similar to what was practiced. The camper and counselor should then begin the 5-minute special playtime.

> You did a great job of completing (state task) and following directions. When you have to do that task later, it will be very similar to what you just practiced, with the suggestions you made. The counselor will give you directions just like he or she just did. You should follow the directions so that you'll finish the task and get back to camp activities quicker, but if you don't follow them, you'll have to take a timeout. What do you think about this? Now, you and the counselor will get to have special playtime for 5 minutes because you did the task so well.

Homework

Upon completion of the special playtime, the trainer should then discuss the upcoming homework with the counselor. The trainer should first review the CODI homework/coaching sheet that the counselor completed, listing the steps involved with the task that was practiced during this coaching session. The trainer should point out that for each command she recorded the outcome on the CODI coding form (Appendix L), for example marking if the command resulted in camper compliance or if there was a warning given and time-out procedure

administered. The trainer will then explain that the homework will be to do what was done during the CODI coaching session that day for real in the same activity that was just role-played.

The counselor should again complete a CODI homework/coaching sheet with the desired goal and the commands involved in achieving that goal, as the counselor had done for this coaching session. The counselor should be directed to modify the steps that were identified initially, based on the experience of the role play, adding steps or clarifying steps, for example. The counselor should administer the activity just as he or she did during this session, using the CODI skills in response to camper behavior. The counselor should record the outcome of each command given on the CODI activity sheet, along with any concerns noted. The counselor should then bring the sheet to session the next day.

The next session will be a direct instruction session beginning the third phase of CCIT, group management. Therefore, counselors should be reminded of this and of the pre-arranged coverage plans for campers. In addition, trainers should ask counselors to think of an activity in which the whole group has difficulty, such as going to the waterfront for the next session.

> Great job with the CODI coaching session. Your homework will be to do what we just did in a role play for real using the same activity. You should first complete another CODI homework/coaching sheet, indicating the task we just role-played and the steps involved in completing that task. You can modify the steps you identified that are involved in completing the task, based on what you learned in session today, for example making steps clearer or adding additional steps, if necessary. You will then go through this activity with the camper, just as we did during this coaching session.
>
> Begin by using CDI skills, then describe what will be expected of the camper, such as we did, stating, "We will now brush teeth, just like we practiced. We will be (identify changes that were instituted in role-play, such as getting new toothpaste or singing a song). It is important to follow directions. If you don't follow directions, you will have to take a time-out. The quicker you follow the directions, the quicker you will be able to return to camp activities." You will then begin by giving the first effective command. You should use the CODI and CDI skills as you go through the activity.
>
> At the end of the activity, first give the camper labeled praise for completing the activity and following your directions. Then debrief with the camper, just like we did,

asking him what he thought about completing the activity. Then you will get the camper into the next activity to show that following the directions will soon lead to being in the next activity.

After you have completed the activity, finish the CODI homework sheet, indicating the responses to each of your commands. Also, note any thoughts or concerns you had about the activity. Please bring this sheet to the next session. The next session will be the beginning of the next phase of CCIT, group management. This session will be an instruction session without campers, so remember to implement the plan for coverage of the campers. Also, I would like you to think of an activity with which the entire bunk seems to have difficulty and be prepared to discuss this activity next time. Thank you.

Session 7

Group Management Instruction

Session Objectives

- Counselors will learn to create a behavioral plan targeting a particular camp activity.
- Counselors will learn CCIT group management skills.

Session Outline

1. Trainers will explain group management and the structure of the group management training phase.
2. Counselors will be taught how to create a behavioral plan, targeting a particular camp activity.
3. Counselors will be taught group management techniques.

Session Materials

1. CCIT manual; and
2. Group Goal Sheet (Appendix M).

Session Explanation

Explanation of Group Management Phase

Trainers will begin by explaining the purpose of the group management phase, how the skills the counselors have previously developed will be used, how counselors can work together to use skills, and how they can manage a group of campers.

> Today we will begin the group management phase of training. All the training you have done up until now will be useful in this phase. This phase will help you learn

how to work together with other counselors to manage camper disruptive behavior with a group of campers. We will address how you can be successful in managing camper behavior in an activity that you will identify as being difficult, or in activities you later find to be difficult. These skills will be useful in many circumstances.

We will start by identifying an activity that is difficult at camp and plan a strategy for how to manage camper behavior in that activity. We will do this by setting up a behavioral plan for campers, establishing camper goals and rewards. I will then instruct you on group management techniques, using the CCIT skills you have learned thus far. In the next session, we will practice these group management techniques in the activity that you have identified.

Identify Difficult Activity

Trainers will lead a discussion with a group of counselors who work with a common group of campers to help them identify an area that they feel is difficult for their group of campers. Trainers will then help the counselors identify what are good goals for their group for this activity. Trainers will then have counselors collectively complete a group goal sheet (Appendix M), incorporating these goals and a reward system. "You were all asked to think about an activity in which your group of campers has had difficulty. I'd like you each to state what area you identified and what difficulties you are experiencing in that area."

Trainers should then wait for counselors to describe the area they have identified. The area that is most frequently mentioned by counselors will be the targeted area for training. If no area is mentioned more frequently than others, trainers should ask counselors to agree on an area to be targeted. For purposes of this manual, it will be assumed that counselors have identified the waterfront as their targeted area, but whatever area counselors really identify should be used in its place. "It seems like the most mentioned area of difficulty is the waterfront. That is the area we will target in this training to come up with strategies for improving camper behavior."

Identify Goals for Targeted Area

Trainers should lead counselors in a discussion to come up with three goals for campers' behavior in the targeted area. Trainers should ensure that counselor goals are specific and attainable. Trainers may need to supply goals for counselors initially to model this process if counselors are having difficulty making their own. These goals should be written in the "Goals" section on the Group Goal Sheet (Appendix M).

> Now I'd like you to come up with three goals that you think would lead to improved camper behavior in this activity. Often these goals may be the opposite of what you identified as being difficult about this area. For example, if you stated that the campers are late getting out of the water at the end of the period, a goal might be to have all campers leave the water within 10 seconds of the end of activity whistle. Just like before when you identified effective commands, goals should be specific and attainable. The goal to have all campers out of the water within 10 seconds of the whistle is specific. It is clear whether the campers achieve this goal or not. It is also attainable. It leaves some time for campers to exit the water. Now I'd like you all to come up with three goals for the waterfront.

Identify Reward for Attaining Goals

Trainers will lead counselors in identifying rewards that campers can get from achieving the identified goals. Trainers will discuss what constitutes good rewards, namely that they are given soon after completing the goals, do not have to be exorbitant, and are motivating to campers. Trainers will also discuss that campers will all be allowed to participate in rewards after completing the goals, even if they experience difficulty in doing so.

> Now I want you to identify what could be a good reward for campers upon completing their goals. A good reward should be motivating for campers, so it should be something they would like. The reward should also be able to be implemented shortly after achieving the goals, so the campers connect achieving the goal with getting the reward. This is especially important if the group of campers are young or if they have difficulties paying attention. An older group of campers might be able to wait a little longer for a reward.

> The reward does not have to be a material good or be a burden to give. In fact, some of the best rewards are to do things together with the camper. So, an example of a good reward for campers who achieve their goals at the waterfront might be that the group gets to have an ice cream social or that the group gets to go on a nature hike during an activity period. In the future, you can involve the campers in planning their rewards to identify rewards that they are interested in. For now, what do you think would be a good reward for campers?

Trainers should facilitate counselors identifying a reward for campers achieving their goals that meets the criteria for a reward identified above. This reward should be written in the Group Goal Sheet.

Presenting Goals and Rewards

The first step in implementing this group management system is that counselors should present the goals and rewards to campers. Trainers should guide counselors in how to do so.

> After you have completed the sheet with the goals and reward specified, you will present this to the campers. This should be presented before beginning the targeted activity. This will help campers remember what the goals are during the activity. You should first explain that there is a new system for the targeted activity and the reason for its implementation, namely to improve behavior at the activity. As a group you should then show the campers the goals and rewards sheet and read the goals and rewards to the campers.
>
> Though there are goals and a reward common to the group, it should be emphasized that the campers who complete the goals will get the reward. So, if I were you and you were campers here is how I would present this system to you, "We have a new plan for the waterfront today. This plan is to help us have a better time there and have everyone follow directions. These are the goals we have for you there (trainer reads identified goals). If you meet these goals then afterwards we have this reward for you," (trainer reads reward).

Group Management Techniques

Trainers should direct counselors that throughout the activity, as well as at other times during the day, counselors should be using CDI and CODI techniques.

During the targeted activity, as well as during other times of the day, all counselors should use CDI and CODI techniques. It isn't expected that you use them as frequently as you used them in special playtime, but by having learned to use them in special playtime coaching sessions so frequently, it will be easier to use them naturally throughout the day.

Selective ignoring/Praise. Trainers should instruct counselors that when they are working with groups of campers, the counselors should try to ignore camper behavior that isn't appropriate, but is ignorable, or still safe. When a camper behaves inappropriately, counselors should use CDI skills to reinforce other campers who are making good choices. This will often result in the camper who was behaving inappropriately to cease the inappropriate behavior and begin to behave in the way for which the other camper is being praised.

When you are working with campers and one of the campers begins behaving inappropriately, but in ways that are still safe, you should try to ignore that inappropriate behavior, much as you did in CDI. While you ignore that behavior, you should give labeled praise to another camper who is behaving appropriately. This will give attention to the camper who is behaving appropriately and encourage him to continue this behavior. That will also likely encourage the camper who is behaving inappropriately to stop the inappropriate behavior and begin to behave appropriately, like the camper whom you praised. This technique should only be used when you haven't given a command, as when you give a command you should follow with the time-out procedure if the camper doesn't comply.

There may be a situation in which multiple campers don't comply with a command. In that case, it is important not to engage in a power struggle with this group of campers who are not complying. If you get in a large power struggle with a group of campers, it can be very disruptive to the group. If there is a large group of campers who are not complying, focus on the group of campers who are complying. Give them praise for complying and get them to the reward or next activity quickly. It can be helpful to separate this group from the group of campers who aren't complying, so that non-compliance doesn't become contagious.

Once the group of campers who complied is taken care of, then focus on the group who isn't complying. Remind them of the command and the reward for complying. This may get some of the campers who aren't complying to comply. You can also reduce the command somewhat to try to get some campers to comply. If some campers comply, then transition them to the group of campers who are complying. Your goal is to minimize the size of the group of campers who aren't complying. Once you

> have the group of campers who aren't complying that is manageable, perhaps one or two campers, then you should follow the time-out procedure.
>
> I'd like you to practice doing this with partners. One partner will be the counselor. Two other partners will be campers, one of whom will be behaving inappropriately, while the other one is behaving appropriately. You will begin this role-play with everyone participating in the targeted activity, in this case being at the waterfront, with the counselor using the CDI skills.

Trainers should ensure that the counselors follow the role play, with counselors in the counselor role using the CDI skills during the activity and then ignoring the camper behaving inappropriately and giving labeled praise for the camper who is behaving appropriately. All counselors should switch roles so that each has an opportunity to play the counselor role.

Timeout procedure in group setting. Trainers should explain how to conduct the time-out procedure when working with a group of campers. Because counselors are responsible for a group of campers, following through with the time-out procedure with a camper who is not complying gives a lot of attention to this camper. This attention might encourage other campers who are behaving appropriately to also behave inappropriately. Therefore, counselors should coordinate with each other to ensure that one counselor is focused on the group of campers who are behaving appropriately, giving them praise and keeping them engaged in the activity.

There should always be at least two counselors with a group of campers to be able to manage the group of campers. While one of the counselors is focusing on the group of campers who are complying, the other counselor will be following through with the time-out procedure with the camper who is not following directions. Trainers should encourage counselors to change roles after administering the time-out procedure longer than 20 minutes. This is to ensure that counselors do not get frustrated during an extended time-out procedure with a camper who is

not following directions for an extended period of time.

Now we will cover how to handle a time-out procedure with a group of campers and counselors. It is important to follow through with the time-out procedure once a command has been given and a camper does not comply. On the other hand, it is important to reinforce the campers who are making good choices. There is a possibility that by focusing on a camper who is not following a command, other campers will join this camper in not following directions because he is getting attention. We want to avoid more campers not following directions. Therefore, when a time-out procedure is implemented, it is important for counselors to work together.

At the beginning of the procedure, a command will have been given and a camper will not have followed it. As per the time-out procedure, the counselor should wait 5 seconds and then give a warning to the camper. If the camper still doesn't comply after the counselor has again waited 5 seconds, a time-out will be given. At this point the counselor who gave the command will communicate to another counselor, who is involved in the activity with the other campers, that she will be administering the timeout procedure. This should be done discreetly so as not to draw attention to the camper who is not complying. The counselor administering the time-out should say, "I'll be using CODI with (camper's name), can you please use CDI with the other campers." This reminds both counselors of what they should be doing in this situation and avoids drawing attention to the time-out procedure.

At this point, the counselor who is with the campers making good choices should continue to be with these campers, engaging in whatever activity the group is doing. This counselor should continue to use CDI skills with these campers and praise them if they are following a command. It is important for the counselor with the campers making good choices not to focus on the camper who is not complying, as this will give attention to this camper and may lead the campers who are complying to begin to not follow directions to get attention. The counselor who is working with the camper who is not following directions should continue the time-out procedure as was covered in this training. It is important to follow through with the time-out procedure so that the camper recognizes that there is a consistent outcome in regard to directions. If the reward is the next activity in which the group is participating, the counselor should remind the camper that she needs to follow directions to participate, just as she reminded her to follow directions to participate in activities previously.

The counselor should stay with the camper until the time-out procedure has completed. If the camper is not following directions for over 20 minutes, counselors should change positions so that a counselor working with the campers making good choices should then come and work with the camper who needs to take a time-out and that counselor works with the campers making good choices. This is to avoid the counselor feeling frustrated with the camper who is not taking a time-out for a long time. Throughout the time-out procedure counselors should remain in communication with each other, so that other counselors may help if more help is needed, such as if the camper begins to become unsafe or the counselor needs something.

So in our example of being at the waterfront, one of the goals might be for the campers to exit the water within 20 seconds. Perhaps all of the campers, except one, exit the water. One of the counselors should then focus on the group of campers who exited the water. That counselor could then take the campers to the bathhouse to get changed, where the next goal might be for the campers to get changed and then go on to the group reward. One of the counselors should remain with the camper who is not following directions and administer the timeout procedure.

Concluding the time-out. At the end of the time-out, counselors should debrief with the camper as is part of the time-out procedure. If the command that wasn't followed was one of the goals, the counselor should remind the camper that this command was one of the group's goals. The counselor should then give the camper the same command. Upon the camper completing the command, he will get credit for accomplishing this goal and will be able to get the reward. Trainers should explain that this gives campers the opportunity to correct mistakes they have made and connects following directions with positive outcomes.

At the end of the time-out procedure, you will debrief the camper as you were instructed previously in the time-out procedure. If the command that wasn't followed was one of the goals, you should remind the camper that this was a group goal. The camper should then be given the command again. If the camper completes the command this time he will get credit for accomplishing the goal and will be entitled to the reward. While this may seem like it is giving the camper credit for something he didn't do initially, it will show the camper that he can correct his mistakes and will help him to connect following directions with good outcomes.

In our example of the group being at the waterfront, one of the campers has not exited the water immediately. The rest of the group is getting changed and going to the ice cream social reward. The camper who didn't exit the water on time delayed taking a timeout, but has eventually taken one. The counselor who has remained with this camper will debrief with her. The counselor will tell the camper that one of the group's goals was to exit the water within 20 seconds. Therefore the camper has to follow this command, to go touch the water and exit the water within 20 seconds. The camper can still achieve the goal if he does this.

I'd now like you to practice this group method with each other. One counselor will play the role of the counselor who gives the command and follows through with the time-out procedure. Another counselor will play the role of the counselor who will work with the campers making good choices. This counselor will use CDI skills, especially

> praise, with the group and continue the activity with them or lead them to the next activity or the reward. Campers who complete the goals will get the reward. Another counselor will play the role of the camper who doesn't comply with the command. The remaining counselors will play the campers who do comply with the command. I'd like the command to be one of the goals that you set for the targeted activity, for example, commanding the campers to get out of the water.

Trainers should ensure that the time-out procedure is followed in the group context, as described above. Trainers should coach counselors during the role play. The role play should not last 20 minutes, but trainers should instruct the group to pretend it has so that counselors may practice switching roles. Trainers should ensure that each of the three goals have been given as commands and that each counselor has a chance to practice each role.

Generalizing the Group Management

Trainers should explain that this group management protocol should be used throughout camp. Trainers should explain how to phase out the goals and rewards in a particular activity. In addition, counselors may wish to target an activity like they did in this training session. Trainers should explain how to recognize when counselors should target an activity and how to do so.

> Good job practicing the group management. You should use this system of interacting with campers throughout the camp. The goals and rewards for each targeted activity can begin to be phased out after the campers have met their goals consistently across several sessions. You can explain to campers that because they have done a good job meeting their goals consistently, there doesn't seem to be a need for the program anymore. If campers object because they won't get the reward anymore, you can target another problematic activity for the group. In addition, you counselors may of your own initiative wish to target another activity that is problematic or perhaps reinstitute the program if camper behaviors become problematic in that same activity. You will know that an activity should be targeted if a number of campers are consistently having difficulty in it. You also will know to target an activity if it remains a problem despite your efforts to use the CCIT techniques, if problematic behavior starts before you can use the CCIT techniques, such as at the beginning of the activity, or if the behavior is especially problematic.

Ending Group Management Session/Homework

Trainers should conclude this session by telling counselors that the next session will take place at the targeted activity with the trainer present to coach them and monitor the implementation. Trainers should guide counselors in completing a Group Goal Sheet for that session, based off the activity and goals established for this practice session. The final homework is for the counselors to administer CODI successfully at another time of the day and record it.

> That concludes this group management instruction session. The next session will take place at the targeted activity that we practiced today, in which you will implement the group management procedures that we practiced. We will use similar goals that you established for the activity today. We can also modify the goals slightly if you think it would be helpful. What goals should we have for the campers for the activity?

Trainers should guide counselors in creating three goals for the activity tomorrow. They should be similar to the goals that were used in this session, but can be modified if indicated. Each counselor should write the activity and three goals on the Group Goal Sheet, which the trainer will collect and disburse to counselors the following day. "The final homework is for you to administer CODI procedures before that session at some time during the day and record that occurrence in the homework sheet."

Session 8

Group Management Coaching Session

Session Objectives

- Trainers and administrators will meet and familiarize themselves with the goals of the program.
- Trainers and administrators will work together to mold the PCIT training experience to meet the needs of the particular camp.

Session Outline

1. Trainers will contact camp administrators.

2. A planning session will take place.

Session Materials

1. CCIT manual;

2. Group Goal Sheets (completed by counselors and collected from previous session); and

3. Equipment for taking notes.

Session Explanation

Prepare for this Session

Trainers will meet for about 10 minutes with counselors before the session begins. The campers should be given an activity to occupy the 10 minutes, such as preparing for the activity or taking a break. A possible method for arranging this is described at the end of this session.

The trainers will remind counselors what the purpose of this session is. Trainers should ensure that counselors have completed the final homework and disburse the Group Goal sheets that the counselors completed the last session back to the counselors.

> Welcome to the final session, the group management coaching session. During this session, all of you will be using all of the CCIT skills and group management techniques to guide the campers through the difficulty activity you have identified. I first want to review the homework you did before this session, which was to use the CODI procedure sometime before this session.

Trainers should ensure counselors have completed this homework, that they have marked all the steps that occurred in the CODI sequence, and review any issues that the counselors have experienced, which they will have indicated on the homework sheet.

Present Goals and Reward to the Campers

Trainers should instruct a counselor to present the goals and reward to the campers. One counselor should identify the goals of the activity, the reward for completing the activity, and how campers will be judged in how they complete goals. Trainers should ensure that this counselor presents the goals and rewards as the counselors were instructed in the Presenting Goals and Rewards section in the previous session. Individual counselors can show each of the campers the goal sheets so that each camper can see what they will do.

> Now I'd like one of the counselors to present the activity to the campers, covering the areas that we identified as being important to present, the goals, the reward, and the goal sheets. While one of the counselors is presenting the activity, the other counselors can show the campers the goal sheets with the goals and reward.

Begin Activity/Coaching

The activity will then begin. Trainers should ensure that counselors are administering the procedure appropriately. Trainers should coach counselors to ensure they are using the CDI skills, the CODI skills, and group management techniques appropriately, as was outlined in the group management instruction session. At this point in the training, trainers should be providing minimal coaching in use of the CDI and CODI skills, as it is assumed that counselors should be proficient in the use of these skills.

Trainers will not be using the two way radios, as there are multiple counselors who they will be coaching. Thus, the trainer should provide feedback to the counselors in person, using a quiet voice and trying to minimize her presence so as not to interfere with the counselors' authority. The trainers should ensure that the group management techniques are implemented appropriately, with counselors communicating to ensure that at least one counselor is giving attention to the campers making good choices, while another counselor works with a camper who is not following directions. Trainers should also ensure that after the CODI procedure is implemented so that the camper has the opportunity to complete the task and is eligible to participate in the reward when the group goals have been met by this camper.

> You will now begin the group management coaching session. During this time you will be using the CDI and CODI skills. You will also use the group management techniques that we have covered to guide campers through the activity and to help them reach their goals. Again, it is important for counselors to communicate and to ensure that the entire group is covered, especially those campers making good choices. Let's begin the activity.

End of Activity

At the end of the activity, the trainer should debrief with the counselors for about 10 minutes and talk about how the activity proceeded. Thus, arrangements should be made for campers to be supervised for about this amount of time. A possible way to arrange this is to have the group of counselors who will begin the next training session supervising their campers, as well as the campers who have just completed this session. Then the counselors who just completed this session can supervise their campers and the other counselors' campers, while these counselors prepare for this session, as described in this session above. During debriefing, the trainer should point out things that the counselors did well and address any issues that need work. Any critique should be framed in terms of what specific behavior the counselors can do next time.

Graduation (optional)

After the trainers have debriefed with the counselors, an optional graduation ceremony can take place. The decision of whether or not to have a graduation ceremony should have already been made with the camp administration. A possible time to have the graduation ceremony could be during the reward that the group has after accomplishing their goals. During this time, trainers can present certificates of completion of CCIT training to counselors and certificates of completion of special playtime participation to campers. Whether or not there is a graduation ceremony, trainers should thank counselors for participating with them in the training, remind them to continue using the CCIT skills, and congratulate all for having finished the training.

Appendix A
Camper Off-task Behavior Chart

Supervisor's name:

Time and Date:

Activity period:

Co-supervisor observing:

Camper Name	Type of off-task behavior	Amount of time (Rounded to 5 minutes)	Percent of on-task behavior (length of activity- amount of time off-task)/length of activity	Amount of time in agreement with co-supervisor

I. Sum of amount of time in agreement with co-supervisor for all campers: _____

J. Total amount of camper time observed (umber of campers observed x Length of time observed:_____

K. Percent in agreement (Blank A/ Blank B from above): _____

L. At least 95% agreement? Yes/No; If "Yes" ratings can be used

Appendix- B

PRIDE SKILLS

DO These

Skill	**Example**
P-Praise	
Labeled Praise	
-Tell the camper what he did well.	- You did a great job putting the (camp toys) away. -You are playing so nicely.
Unlabeled Praise	
-Not specific praise.	-You did a great job. -Way to go!
R-Reflect	
-Repeat what the camper said.	-Camper says, "This project is hard," then counselor says, "It *is* hard!"
I-Imitate	
-Imitate what the camper is doing.	-If the camper is building a model, the counselor starts building a model. -If the camper is making animal noises, the counselor also makes them.

D-Describe

-Describe what the camper is doing.	-If the camper is building a craft, the counselor describes this process, "You are looping the pieces together. You are alternating the colors, etc."

E-Enthusiasm

-Show enthusiasm in voice and actions.	-Smile, seem excited to be with the camper, change tone of voice, etc.

DON'T DO These

Behavior	**Example**
Command	
-A command tells the camper what to do And controls the play.	-Put the block over here. -Let's clean up.
Question	
-A question also controls the play by Making the camper answer.	-Isn't this fun? -What should we do next?
Criticism	
-Criticism takes away the fun from play.	-Don't play so quickly. -That doesn't go there.

-Based on PCIT Manual, Hembree-Kagan & McNeil, 2010

Appendix- C.1

Appropriate Toys for Special Playtime for Younger Campers

Choose toys for special playtime that help you and the camper to have a positive experience, and that can be done calmly while sitting down. In each "Choose" category, think of one or two types of toys that fit the categories and are available at the camp. Types of toys to choose include those that are:

Choose	**Examples**
Creative- Toys which the child can use how he wants & encourage child-led play.	-blocks/Lincoln logs -art supplies -_____ -_____
Cooperative- Toys which the child can use with the counselor.	-crafts -puzzles (large <25 pieces) -_____ -_____
Fun- Toys which the camper and counselor can enjoy using together.	-Mr. Potato Head -sock puppets -_____ -_____

Types to avoid are:

Don't Choose	
Aggressive- Toys which lead to aggressive play can over-stimulate the camper.	-guns -boxing gloves -_____
Rules- Games with rules take away from the child being able to lead the play.	-board games -card games -_____

No Interaction- Toys that lead to no interaction don't give you a chance to practice CDI skills.

-books
-TV
-_____

Too unreal- Activities that lead to the camper to be someone or something else can be confusing for her to connect the special playtime to herself.

-masks
-make-believe
-_____

Too chaotic- Activities that could get out of control could lead to negative interactions and setting limits.

-finger-painting
-scissors
-_____

Appendix- C.2

Appropriate Toys for Special Playtime for Older Campers

Choose toys for special playtime that help you and the camper to have a positive experience, and that can be done calmly while sitting down. In each "Choose" category, think of one or two types of toys that fit the categories and are available at the camp. Older campers will value more advanced and engaging toys. Types of toys to choose include those that are:

Choose	**Examples**
Creative- Toys which the child can use how he wants and encourage child-led play.	-modeling clay -bead sets -car models -_____
	-_____
Cooperative- Toys which the child can use with the counselor.	-origami projects -puzzles (smaller >25 pieces) -_____
	-_____
Fun- Toys which the camper and counselor can enjoy using together.	-action figures -ventriloquist puppet -_____
	-_____

Types to avoid are:

Don't Choose	
Aggressive- Toys which lead to aggressive play can over-stimulate the camper.	-guns -boxing gloves -_____
Rules- Games with rules take away from the child being able to lead the play.	-board games -card games -_____

No Interaction- Toys that lead to no interaction don't give you a chance to practice CDI skills.

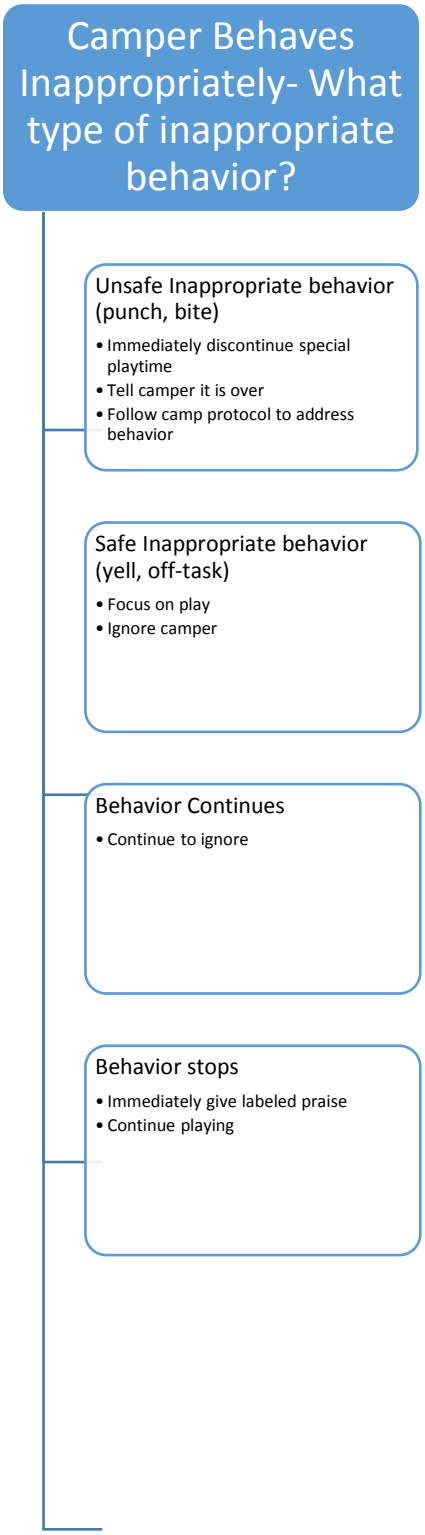
-books
-TV
-_____

Too unreal- Activities that lead to the camper to be someone or something else can be confusing for her to connect the special playtime to herself.

-masks
-make-believe
-_____

.

Appendix- D: Ignoring Flowchart



Appendix E

CDI Benefits

- Helps communication and maintain camper attention.
- Builds camper/counselor relationship.
- Improves camper enjoyment with counselor.
- Positive behavior management techniques.
- Improved camper self-esteem/decreased frustration.
- Necessary skills for CODI.

Appendix F
CDI Special Playtime Homework

Counselor: _____

Camper:_____

Expected Special Playtime Time
(Activity Period/Time):_____

Expected Special Playtime Toys:_____

Expected Special Playtime

Special Playtime Rules (to be read to camper at the beginning):

"During Special Playtime:
1. Play nicely;
2. What falls on the floor (or away from sitting area) stays there;
3. Stay in your seat (or on the sitting area)."

PRIDE Skills (Use as many PRIDE skills as you can.)
P-Praise R-Reflect I-Imitate D-Describe E-Enthusiasm

Checklist of Special Playtime Procedures: (Check each box that you completed after special playtime is over.)

Event	State Rules	Time 5 minutes	Use CDI skills	Use ignoring
Check				

Note anything you would like to discuss with the trainer or questions:
-

_____
_____
_____

Appendix G.1

CCIT DPICS CODING FORM (Younger Camper)

Counselor's Name:_____

Camper's Name:_____

Date/Session:_____

DO Behaviors (Tally each occurrence and total/Circle when appropriate):

Skill	**Tally**	**Total**	**Mastery Goal**
Labeled Praise			10
Unlabeled Praise			-
Reflection			10
Describe			10
Imitate	Sufficient/Not Sufficient	-	-
Enthusiasm	Sufficient/Not Sufficient	-	-

DON'T Behaviors (Tally each occurrence and total):

Behavior	**Tally**	**Total**	**Mastery Goal-** Less than 3 total
Criticism			0
Question			0
Command			0

Ignoring:
Was ignoring used (circle one)? Yes No Not Applicable

Was mastery met ("Do behavior" goals met + "Don't Behaviors" less than 3 +Ignoring, if applicable)?

Yes No

Appendix G.2

CCIT DPICS CODING FORM (Older Camper)

Counselor's Name:_____

Camper's Name:_____

Date/Session:_____

DO Behaviors (Tally each occurrence and total/Circle when appropriate):

Skill	**Tally**	**Total**	**Mastery Goal**
Labeled Praise/ Unlabeled Praise			7 (at least 4 Labeled)
Reflection			7
Describe			7
Imitate	Sufficient/Not Sufficient	-	-
Enthusiasm	Sufficient/Not Sufficient	-	-

DON'T Behaviors (Tally each occurrence and total):

Behavior	**Tally**	**Total**	**Mastery Goal-** Less than 3 total
Criticism			0
Question			0
Command			0

Ignoring:
Was ignoring used (circle one)? Yes No Not Applicable

Was mastery met ("Do behavior" goals met + "Don't Behaviors" less than 3 +Ignoring, if applicable)?

Yes No

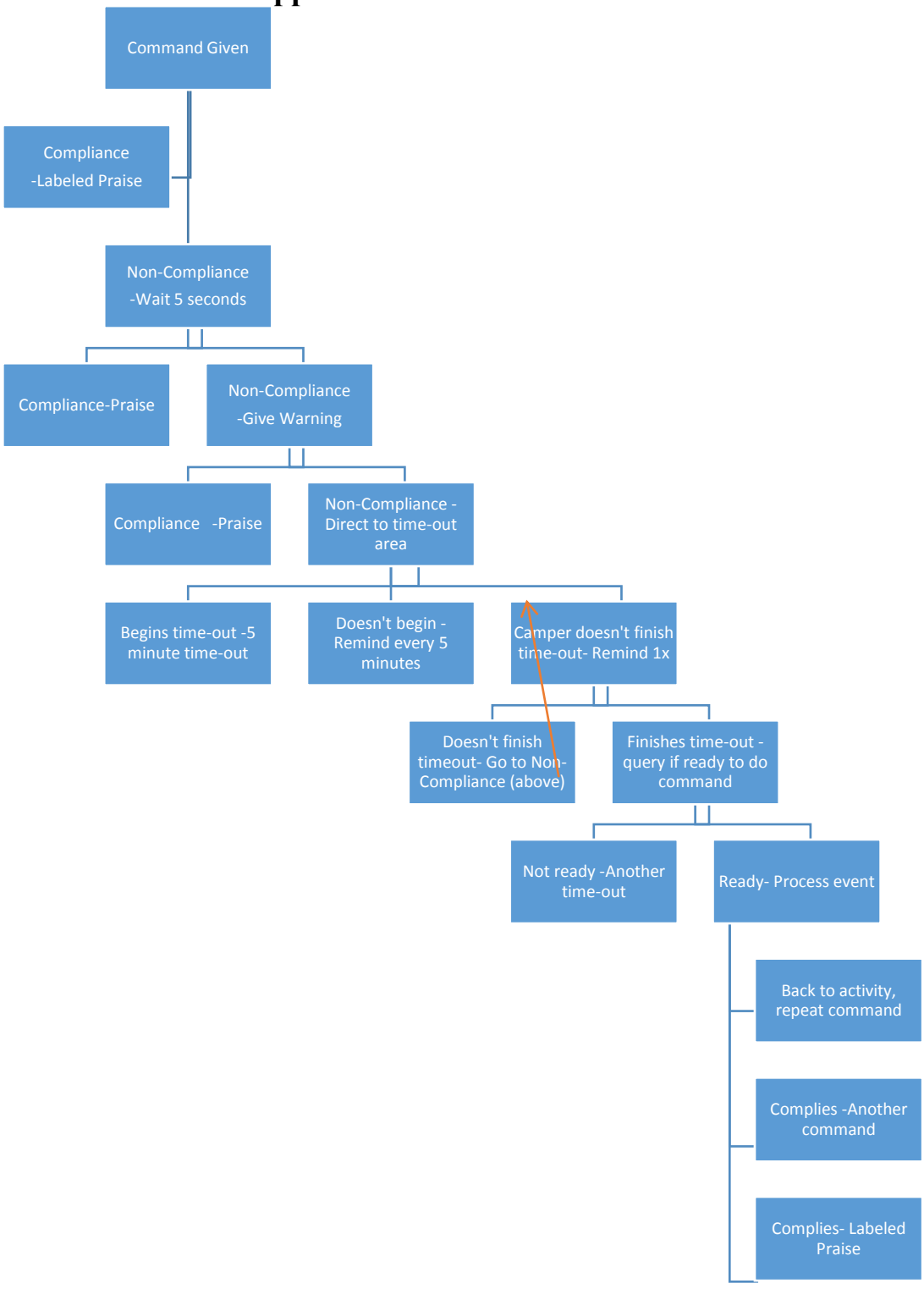
Appendix H
EFFECTIVE COMMANDS

Commands should be:

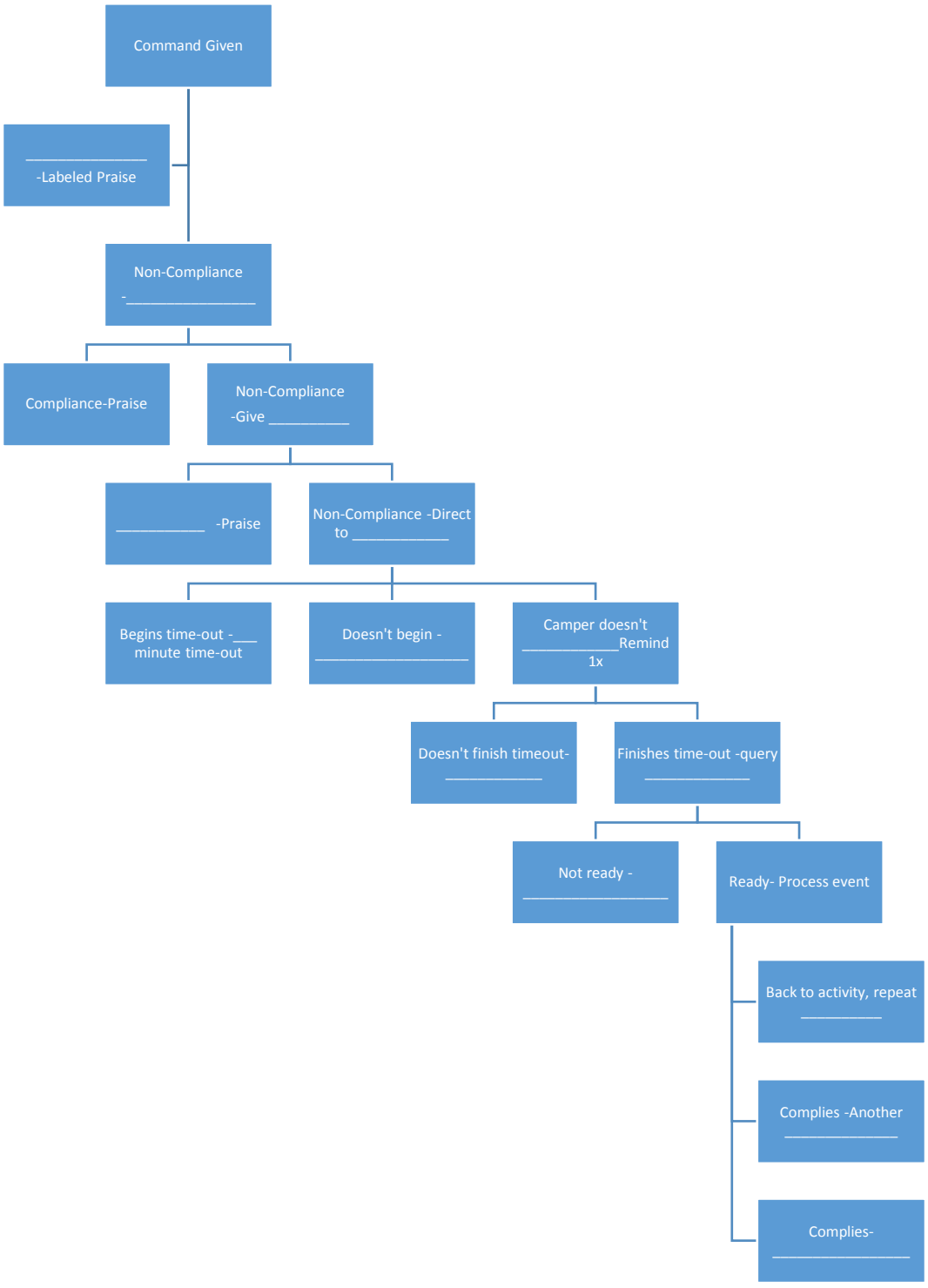
Rule	Reason	Example
-Direct, not Indirect	-Easy to understand. -Clear it's a command.	-"Give me the toy." (Not, "How about giving me the toy.")
-Positive, not Negative	-Camper knows what to do.	-"Sit down." (Not, "Stop standing up.")
-Specific, not Vague	-Camper is clear about what is expected.	-"Put the Legos back in the box." (Not, "Put that toy away.")
-One step, not More	-Camper can remember each step.	-"Take apart the Legos." (Not, "Clean up.")
-Age appropriate	-Camper can understand.	-"Put the toy in its box." (Not, "Put the toys in their corresponding boxes.")
-Polite, not impolite	-Teaches camper to be calm. -Conveys respect.	-"Please give it to me." (Not, "Give me that toy right now!")
-Explained before the command or after compliance	-Discourages "Why?" -Not confusing.	-"Cleaning up helps us get to the next activity. Please put the toy in toy in the box." (Not, "Put the toy away. We have to get to the next activity.")

-Only given when necessary (Avoid small battles)	-Every command should be followed through -Less frustrating	-“Please sit down.” (Not, “Don’t move in your seat,” as it is not possible for a child to remain totally still)

Appendix I: CODI PROCEDURE



Appendix J
CODI COMPLETE BLANKS ACTIVITY



Appendix K

CODI HOMEWORK/COACHING

Counselor Name:_____

Camper Name:_____

CODI Homework Time/Activity:_____

1. Begin by introducing special playtime
2. Use CDI skills for first 3 minutes
3. Introduce CODI
    a. "I will now give you directions."
    b. "I want you to do what I tell you."
    c. "If you do what I tell you, we can keep playing. If you don't do what I tell you, you'll have to sit in time-out."
4. Give effective commands
5. Follow CODI procedures (check boxes for each step followed)

1. Give Command _____	2. Compliance -Labeled Praise _____	3. Non-Compliance – Warning _____	4. Compliance-Praise _____
5. Non-Compliance-Time-Out _____	6. Begin time-out for 5 min. _____	7. Doesn't begin- Remind every 5 min. _____	8. Doesn't finish time-out- Remind once _____
9. Finishes time-out- Query if ready to comply _____	10. Ready-Process event _____	11. Ready- Give another command _____	12. Not ready-Give another time-out _____

13. Ready- Give same command _____	14. Complies- Give another command _____	15. Complies- Labeled praise _____	

Note (any issues or questions)

Camper to bring to next coaching session: _____

Area of difficulty to focus on next session: _____
Steps involved in that area:
1._____
2._____
3._____
4._____
5._____

Appendix L

CODI CODING FORM

1. Trainers should check for each step completed in a time-out procedure. The goal is to complete steps 1-4 with 75% accuracy and to administer the time-out procedure (5-15) without missing any steps.

1. Give Command _____	2. Compliance -Labeled Praise _____	3. Non-Compliance - Warning _____	4. Compliance-Praise _____
5. Non-Compliance-Time-Out _____	6. Begin time-out for 5 min. _____	7. Doesn't begin- Remind every 5 min. _____	8. Doesn't finish time-out- Remind once _____
9. Finishes time-out- Query if ready to comply _____	10. Ready-Process event _____	11. Ready- Give another command _____	12. Not ready- Give another time-out _____
13. Ready- Give same command _____	14. Complies- Give another command _____	15. Complies- Labeled praise _____	

Time out procedure goal met (Circle one)? Yes No

2. 4 Effective Commands given (check if any of the rules were violated)? Yes No

a. Direct _____ b. Positive____ c. Specific_____ d. One-step_____ e. Age-appropriate ____ f. Polite ____ g. Explained before command/after compliance ____ h. Necessary____

Appendix M
GROUP GOAL SHEET

Target Activity:_____

1.
Goal:_____
___
Goal 1 Done (Check)**? Yes**_____ **No**_____

2.
Goal:_____
___
Goal 2 Done (Check)**? Yes**_____ **No**_____

3.
Goal:_____-
____
Goal 3 Done (Check)**? Yes**_____ **No**_____

REWARD!_____
_____

End of CCIT Manual (Appendix F)