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The Effect of Parent-Child Interaction Therapy on Caregiver Rigidity, Job Satisfaction and Childhood Misbehavior

Victoria Tackett Riley
University of South Carolina - Aiken, RILEYVT@email.usca.edu

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Victoria Tackett Riley

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Abstract

This research studied the effects of Parent-Child Interaction Therapy (PCIT) training in a residential care facility for children with histories of maltreatment. Initially, five direct care staff were trained to provide an adapted version of PCIT to a randomly assigned child in the facility. The goal was to improve staff's interactions with the children in their care and increase job satisfaction while decreasing the instances of misbehavior among those children. Data was recorded four times (pre, during, and post intervention) to assess the efficacy of the intervention and included completion of the Eyberg Child Behavior Inventory (ECBI), the Rigidity scale of the Child Abuse Potential Inventory (CAPI), and a Job Satisfaction Survey (JSS). Although the results did not provide statistical significance to support the hypothesis that training in PCIT would reduce instances of misbehavior, training in PCIT was associated with increased job satisfaction and decreased rigidity levels in direct care staff. Twenty eight additional participants were later added to test relationships between job satisfaction, child misbehavior and rigidity. Statistically significant relationships were found between perceived childhood misbehavior and caregiver rigidity, however correlations between child misbehaviors with job satisfaction and rigidity with job satisfaction did not yield statistical significance.

The Effect of Parent-Child Interaction Therapy on Caregiver

Rigidity, Job Satisfaction and Childhood Misbehavior

According to the US Department of Health and Human Services (US DHHS), each year

two to four percent of maltreated children are removed from their homes. This statistic represents

between 14,000 and 28,000 children who are introduced into out of home care each year (US

DHHS, 2009). Reasons for removal vary by situation and state, but often removal from the home

is considered a temporary situation while accusations of maltreatment are being investigated.

Once children are removed from the home however, it is common for them to engage in defiant

and oppositional behaviors (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005). This

coupled with the fact that disciplinary training is not customary for those working with children

who have been removed from their homes may create a scenario of cyclical behavioral issues for

children and frustration for adult caregivers. In a group home situation, this problem is magnified

as multiple children are cared for by multiple caregivers. Under these circumstances, a

standardized disciplinary technique would seem to be invaluable; however, few studies have

investigated the efficacy of such a methodology. The current study investigated the effects of

training in an empirically supported interactive therapy on caregivers and their charges in a local

residential facility for maltreated children and also examined the correlations between job

satisfaction, child misbehavior, and rigidity.

Child maltreatment has typically been delineated into one of two categories: abuse

(physical, emotional, sexual) or neglect. The Keeping Children and Families Safe Act of 2003,

defined child abuse and neglect as: "any recent act or failure to act on the part of a parent or

caretaker which results in death, serious physical or emotional harm, sexual abuse or

exploitation; or an act or failure to act which presents an imminent risk of serious harm" (108th

Congress, 2003, p. 44). The Federal Child Abuse Prevention and Treatment Act (CAPTA, 2009) provides standard descriptions that individual states must use in their definitions of abuse and neglect. These include general abuse and neglect and sexual abuse defined, in part, as any type of sexual exploitation of children (e.g., direct contact with the genitals, exposure to pornographic materials, etc.). According to statistics compiled from the 50 states, District of Columbia, and Puerto Rico by the US DHHS, there were 772,000 confirmed cases of child maltreatment in the year 2008. Of those cases, 71.1% were due to neglect, 16.1% were due to physical abuse, 9.1% were due to sexual abuse, and 7.3% were due to psychological maltreatment. Although the ages of the victims ranged from 0 to18 years, 69.3% of the confirmed cases involved children under the age of eight (US DHHS, 2009).

Parenting Factors in Child Maltreatment

According to the developmental-ecological framework introduced by Asawa, Hansen, and Flood (2008), varying risk factors and contexts are present within a family that may lead to child maltreatment. Risk factors have been organized by domains of parent factors, child factors, factors in the immediate interactional context, and those existing in the broader environmental context (Asawa et al., 2008). The current study focused on risk factors from the adult's perspective (rigidity and job satisfaction) and factors related to the child (perceived misbehaviors). Abusers may have low self-esteem, low self-control, and difficulty feeling empathy toward others. They may also view their children's perceived misbehaviors as purposeful and defiant and feel that parenting is especially difficult (Asawa et al., 2008). Caregivers who rank high on unhappiness and/or rigidity scales may present a disciplinary style lacking in warmth and/or may present their children with disorganized interactions. These influences can impede the child's ability to develop a sense of social awareness and may

eventually lead to defiant or aggressive behavior at home, at school or in various social situations (Dodge, 1990).

Factors innate in the child (low birth weight, developmental disabilities, etc.) may increase the possibility of abuse. Children of younger ages are also more at risk due to their lower level of maturity and development. Risk factors associated with a higher risk of sexual abuse, in particular, include the childhood traits of low self-esteem, lack of knowledge of personal safety skills, and lack of social support (Asawa et al., 2008). These factors are typically more prevalent in children without a strong parent-child bond and/or a positive parent-child interaction style. Although a variety of causes leading to abuse and/or neglect have been discussed, it is apparent that the interaction between child and caregiver is a contributing factor that may result in maltreatment.

A study by Herrenkohl, Herrenkohl, and Egolf (1983) indicated that instances of maltreatment, especially physical abuse, are more often than not the result of circumstances that are common in child rearing (crying, bed wetting, eating issues, etc.), and not those behaviors that are generally perceived as socially unacceptable (stealing, fighting, truancy, etc.). Caregivers who have rigid and high expectations may have difficulty discerning behavior that would be typical in the child's age group. In other words, offenders may point to child behaviors that are developmentally appropriate as the trigger for abuse. The problem lies in the adults' perception of that behavior. Therefore, child abuse and maltreatment can often be seen as the result of flawed adult-child interaction.

Parenting style may also be a factor in the incidence of childhood neglect and abuse. In the early 1960's, Baumrind (1967) conducted a study of more than 100 preschool children and their parents. Using naturalistic observation and other research methodology, she identified four

dimensions of parenting (disciplinary strategies, warmth and nurturance, communication styles, and expectations of maturity and control) and, based on these dimensions, identified three styles of parenting. Baumrind (1967) labeled these types authoritarian, authoritative, and permissive.

According to Baumrind, authoritarian parents set high demands on their children but are emotionally unresponsive when the goals are met. They expect their children to obey a set of strict rules but give them no input as to the purpose behind these edicts. Theirs is a "because I said so" mentality and they expect the rules to be followed without benefit of explanation. Their children are likely to be obedient and capable but tend to rank low on social competence, self-esteem, and happiness scales (Baumrind, 1967).

Permissive adults, on the other hand, make little demands of their children. They tend to underestimate the child's maturity and have low expectations of the child's self-control. They are indulgent and nurturing but are inclined to take on the role of friend, not parent. Children of permissive parents rank low in happiness and self-regulation and may have trouble in school, especially with authority figures (Baumrind, 1967).

The authoritative type of parent establishes rules and guidelines but allows discussion about their expectations. If goals are not met they are supportive and assertive but not overly punitive. Authoritative parents are more democratic and understanding when compared to authoritarian parents. In addition, they communicate standards for their children instead of making demands. Children of authoritative parents tend to be better adjusted, content, and successful in their endeavors (Baumrind, 1967). The effectiveness of this disciplinary/parenting method aids in a more positive adult-child interaction.

In 1983, a fourth parenting type, uninvolved, was identified by Maccoby and Martin. This style of parenting is characterized by minimal attention given to the child and few demands

made upon them. The parent may fulfill the basic needs of their offspring, but little else. In extreme cases uninvolved parents are so detached that even the child's basic needs are neglected. Children of uninvolved parents typically rank lowest across all domains. They may lack self-control and self-esteem and are usually less confident than their peers (Maccoby & Martin, 1983).

According to a 2000 study involving 631 families with disruptive first grade children, parenting practices that included punitive interactions (common in authoritarian parents) were associated with elevated rates of all child disruptive behavior problems. Low levels of warm involvement (typical of both uninvolved and authoritarian types) were particularly characteristic of parents of children who showed elevated levels of oppositional behaviors. Physically aggressive parenting was linked more specifically with child aggression (Stormshak, Bierman, McMahon, & Lengua, 2000). Other studies have indicated a positive correlation between authoritative parenting styles and lower incidence of oppositional behavior. As explained previously, authoritative parenting involves a mixture of warmth and behavioral expectations that leads to more positive and effective parent-child interactions. One way to introduce this type of interaction is through a therapeutic method known as Parent-Child Interaction Therapy or PCIT.

Parent-Child Interaction Therapy

PCIT was developed in 1974 by Sheila Eyberg. It is based on the principle that the authoritative parenting style (firm, limit setting, and warm) leads to the most positive outcomes for children. PCIT incorporates components of behavior therapy, play therapy, family systems therapy, and social learning theory and was originated to assist parents in disciplining defiant or developmentally disabled children. The age of therapeutic focus for PCIT is typically two to

seven years although children with maltreatment histories may benefit through age eight (Bell & Eyberg, 2002). In a subsequent update to their text, *Parent-Child Interaction Therapy,* Hembree-Kigin and McNeil (2010) introduced adaptations to traditional PCIT which may be useful in interactions between adults and children up to age ten. The changes in CDI in this expanded version of the text include using fewer verbalizations during the child directed portion of PCIT. It is also recommended that play time be extended from the five minutes recommended with younger children to ten minutes in older children (8-10 years of age).

Parent training before the introduction of PCIT typically involved a relationship enhancement approach which involved parents using play therapy in the home to enhance the parent-child bond (e.g., Guerney, 1964) or a behavioral therapy approach centering on the modification of maladaptive behavior (e.g., Costello, 1967). PCIT, which was based on Hanf's two stage treatment model, incorporated both. In 1969, Constance Hanf developed a combined model to assist mothers of developmentally disabled children in gaining compliance. In the first stage of the Hanf model, parents were taught to give appropriate reinforcement for positive behavior while ignoring negative behavior. In stage two, the parents were instructed to give clear commands ("Put the red block in the toy box"), using praise with a compliant child, and using time-out as a punishment for noncompliance (Foote & Schuhmann, 1998; Hembree-Kigin & McNeil, 1995). After evaluation of Hanf's two stage model and understanding the therapeutic value of playful interaction between child and caregiver, Eyberg added a play therapy component in PCIT. In the play situation, caregivers follow the child's lead during a daily five minute play period and continue giving differential attention to adaptive and maladaptive behaviors. Children are given attention while parents describe the child lead activity using specific types of

interaction (imitating the child's actions and reflecting and expanding on their verbalizations, etc.; Hembree-Kigin & McNeil, 1995).

Considering the influence that parents have over the development of their children, one of the tenets of PCIT is that caregivers be involved in the training along with their child. In fact, Hembree-Kigin and McNeil state that parental involvement is important in any type of therapeutic work involving a child of preschool or early elementary school age especially (Hembree-Kigin & McNeil, 1995). According to Eyberg (1988), many childhood behavior problems originate with problems in parent-child interaction. Even those children with problems seemingly originating in their biological makeup (such as those with autism, hyperactivity, or a difficult temperament) have issues that seem to be intensified by lack of positive parent-child interaction. Thus PCIT training involves not only training the caregivers but also observing the adult-child interaction in order to gauge the proficiency of the caregiver in the PCIT skills.

In the PCIT model, stage one is labeled child-directed intervention, or CDI. It can also be described as the Relationship Enhancement stage. During this phase of training, participants are instructed in the basic skills of behavioral play therapy including presenting and modeling "do" and "don't" skills and discussion of strategic attention and selective ignoring. Caregivers are asked to set aside five minutes daily to focus on this one-on-one play period with their child (Hembree-Kigin & McNeil, 1995).

"Do" skills (also known by the acronym PRIDE: praise, reflect, imitate, describe, enthuse) include complimenting the child using labeled praise (specific remarks such as "You choose such pretty colors!", "I like it when you build quietly!") as opposed to nonspecific praise (e.g., "Good!" or "Nice job!"). Adults are also instructed to reflect the child's speech by repeating or paraphrasing what the child says, to imitate the child directed play by simply

following the child's lead, to describe the actions as they occur, and to show enthusiasm throughout the play period (Eyberg, 2010).

As one of the "Don't" skills, adults are asked to refrain from giving commands during CDI as the child is the leader during this interaction. They are also instructed to avoid asking questions, or criticizing the child during the five minute play period. The reason for abstaining from these interactions is that they interfere with the desired process. Questions take over the lead of the interaction from the child and may indicate that he or she is not being listened to. Criticism lowers a child's self-esteem and creates a negative interaction, which is the opposite goal of CDI (Eyberg, 2010).

Caregivers are also asked to give attention to positive behavior of the child while ignoring instances of whining, yelling or talking back (non-aggressive negative behaviors). Adults are directed to continue ignoring until the child does something positive, and then praise the positive behavior (using the "Do" skills if possible). Ignoring maladaptive behaviors while giving attention to the positive shows the child which of their behaviors result in attention from the adult. Seeking attention is typically a primary goal of negative behavior in children (Eyberg, 2010).

Some of the benefits of child-directed interaction include improvement in the child's self-esteem and the parent-child relationship. It may also help children learn to handle anger and frustration more effectively. This portion of PCIT is considered a therapeutic intervention and its importance during training sessions should be conveyed as such (Hembree-Kigin & McNeil, 1995).

The second phase, known as parent-directed interaction (PDI) is also known as the Behavior Management phase and is expected to be used whenever needed (in instances of

noncompliant behavior). Instruction in PDI includes teaching how to give effective commands (specific, age appropriate, etc.) and how to set up and handle time out in the event of noncompliance (Eyberg, 2010). This type of interaction is necessary to teach children the importance of following rules, which also aids in proper socialization. Children who have not learned to comply with rules set by parents are likely to have more difficulty adjusting to school or other social settings. Compliance also aids in peer acceptance as children who have learned to follow rules are more likely to behave positively in situations such as group play and one-on- one interaction (Hembree-Kigin & McNeil, 1995).

The development of conduct problems in children may begin in infancy but commonly becomes apparent between the age of 3 and 4. Children in these early stages of development are also the most vulnerable to poor quality parenting (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). This set of circumstances (negative conduct and poor parenting) may lead to ongoing parent-child interaction problems while contributing to oppositional and/or defiant behavior and poor peer relationships. Several empirical studies have demonstrated the efficacy of PCIT as an effective disciplinary tool in child-parent dyads (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, 1988; Eyberg, Funderburk, & Hembree-Kigin, 2001; Eyberg & Robinson, 1982). Others have confirmed the ability of PCIT in maintaining these positive effects up to two years post-treatment and beyond (Eyberg et al., 2001). In 2003, Hood and Eyberg examined the effectiveness of PCIT three to six years post-treatment. Their study indicated that even after a significant passage of time, the skills introduced in PCIT were able to improve the interaction between parent-child dyads. PCIT has also proven to be successful in educating caregivers in the effectiveness of PRIDE skills (Praise, Reflect, Imitate, Describe, be

Enthusiastic) which aids in producing cooperation in previously oppositional children (Hood &

Eyberg, 2003).

Foster parent-child relationships have also shown improvement after PCIT training.

Many children in foster care have been subjected to abuse and/or neglect. These experiences,

especially if they occur during preschool ages, puts children at risk for problems in social,

psychological, and psychobiological areas (Timmer, Urquiza, & Zebell, 2006). General issues

with mental health are also more prevalent in children who have been removed from their

biological parents and placed in foster care, particularly if they are placed in multiple homes.

These recurring issues (social, psychological, and psychobiological problems) increase the

possibility of multiple placements, which in turn increases the possibility of mental health

problems and oppositional/defiant behaviors. The result is a cyclical existence of placement,

removal, and an increase of negative behaviors (Timmer et al., 2006). Meanwhile, foster parents

are typically given very little instruction on dealing with children who may have psychological

issues. In a 2006 study, Timmer et al. tested the effectiveness of PCIT on 75 foster parent-child

dyads in comparison with 98 non abusive biological parent-child dyads with children in

treatment for behavior problems. Their results indicated overall improvement in child behaviors

and caregiver stress in both groups. They recorded no significant differences between the adults

in either group, indicating the effectiveness of PCIT in foster parent training.

In their 2005 study, McNeil et al. focused on training foster parents in PCIT skills.

According to statistics, 10-12% of children in the general population engage in clinically

significant behavior problems that could be improved with intervention (McNeil et al., 2005). In

foster care these numbers increase dramatically to 50-61% (McNeil et al., 2005). These

behaviors, if left untreated, may manifest themselves in adolescent delinquency and adult anti-

social behavior. The McNeil et al. (2005) study involved 30 foster families with children who had exhibited behavior problems. The training was conducted in a group over two consecutive days. Although this did not allow time to practice CDI and PDI skills, the results indicated that the program of instruction in CDI and PDI skills was successful in decreasing negative behaviors and increasing positive adult-child interaction. At one and five month follow-ups, foster parents reported behavior within normal ranges (McNeil et al., 2005).

Training in PCIT has also proven effective in increasing positive adult-child interactions within a group setting. Although PCIT was developed as a means to increase positive interaction in one to one child-parent dyads, it has been modified and its efficacy tested in several other venues, including those involving groups of children. In a study published in 2006, researchers implemented a revised form of PCIT called Teacher-Child Interaction Therapy (or TCIT) in eight head start programs in Pennsylvania. Results in this study were mixed but the researchers found an overall increase in positive child behaviors. An increase in labeled praise among teachers in both groups was also recorded (Tiano & McNeil, 2006). In a 1996 study involving 23 child-parent dyads in a Head start program, researchers found an improvement in parent-child interactions after implementation of PCIT. The study was carried out in the hope of increasing positive parenting in this group which was considered at risk for behavioral and dyadic interaction problems. Four weeks post-training, parents were using praise and direct commands more effectively and describing their children's play more frequently. Description of play is one of the "Do" skills involved with PCIT. Parents are asked to describe the child directed play as if they are announcing a sporting event. This helps keep the child in the lead and lets the child know the parent is paying them appropriate, positive attention (Pollock, 1996).

Studies have also been conducted with TCIT in typical preschool settings. Filcheck, McNeil, Greco, and Bernard (2004) initiated a study in a preschool classroom of 17 students described as "out of control." Their study evaluated the effectiveness of a class wide Level System of reward when compared to existing behavior devices in place in the classroom and to the CDI and PDI components of TCIT. The Level System used a chart with each child represented. It tracked behavior several times throughout the day by placement of markers (progressively sunny happy faces, progressively darker sad faces, and neutral sections). Throughout the day, those children with markers in a sunny area could reap rewards (stickers, activity with teachers, etc.) after which all students (in both positive and negative placements) would be returned to the neutral area. The results supported the use of both the Level System and TCIT to manage misbehaviors in the classroom. The instance of inappropriate behavior decreased after implementation of the Level System and became even less frequent as TCIT skills were introduced. After introduction of CDI and PDI skill training a more positive classroom environment was recorded including more frequent use of labeled and unlabeled praise by teachers and less frequent use of critical statements (Filcheck et al., 2004).

In 2006, Pade, Taube, Aalborg, and Reiser evaluated a program for children aged two to five who were referred due to noncompliance issues or behaviors such as excessive destructiveness, fighting, or hitting other children. Parental report indicated a lack of ability to control their children's' behavior, along with feelings of failure, embarrassment, and exhaustion. Parents also reported frequent urges to hit their child. The program, Tots, is a temperament-based interactive behavioral group therapy that utilizes PCIT techniques. Information and training was disseminated to groups of parents of young children with oppositional or defiant issues as indicated by parent report. The Tots program included 10 training sessions and five of the seven

elements of PCIT including live coaching, standardized assessment measures, and assigned homework. It also used skills from the CDI and PDI modules of PCIT. The study assessed current and long term (5-6 years) effects of the training. In this population ($n = 73$ in pre and post treatment, $n = 23$ in the follow up condition), it was found that the abbreviated interaction therapy had both immediate and long term benefits. Adults in the program did not typically report problems with interactions with their child but rather blamed any behavioral issues on their "difficult child;" however, after improving the parent-child interaction, fewer behavioral problems were reported overall (Pade et al., 2006).

TCIT has also shown effectiveness in one-on-one teacher-student interactions. In a 2000 case study involving a 2-year old preschooler, McIntosh, Rizza, and Bliss implemented Teacher-Child Interaction Therapy (TCIT) as a means to reduce misbehaviors and improve teacher-student interaction. According to teacher report, the participant had not adjusted well to the classroom, frequently hitting, kicking, and biting classmates and displaying oppositional and defiant behavior toward the instructor. Following training and implementation of TCIT skills, an increase in positive teacher-child interaction and compliance was recorded along with a decrease in disruptive behaviors (McIntosh et al., 2000).

Further studies have investigated the relationship between TCIT and child compliance. In 2009, Lyon et al. examined the need for a preschool training program to support social and emotional development in children of low socio-economic status. In this intervention, teachers received training in the support of social-emotional development in young minority children with low socio-economic status. The results showed systematic increases in trained skills (both child and adult directed interactions) during intervention, and participant evaluations showed that the training was rated positively. The data collected in this study suggested that TCIT demonstrates

effectiveness in increasing positive teacher-child interactions in preschool populations (Lyon et al., 2009).

In a 2010 study, Gershenson, Lyon, and Budd conducted training with preschool teachers in a childcare facility serving mostly low income, ethnic minority families. There were 78 children within the four classrooms of those involved in the training. The goals of training included reducing child misbehaviors and teacher burn-out by introducing an empirically supported, standardized form of adult-child interaction. The training was well received by participants. The researchers concluded that it is critical to continue this type of professional development to assist in reducing high teacher turnover which is especially common in community based preschool programs. Since many of the children involved in this particular preschool program had been witness to domestic violence, they likely had been subjected to a haphazard disciplinary style which manifested itself in oppositional and defiant behaviors (Gershenson et al., 2010).

In a 1991 study by Fantuzzo et al., level of impairment was directly correlated with the type of abuse witnessed as well as the stability of the home environment. Children who were placed in shelters even briefly displayed more impairment in social skills than children in comparable situations who did not leave their homes (Fantuzzo et al., 1991). These children may also demonstrate high levels of defiance, especially toward parents (Lemmey, Figueredo, & Koss, 2001). Any of these factors resulting from witnessing violence might also add to the impairment of parent-child interaction. It is apparent that children who witness domestic violence in general, and those placed in shelters in particular, may benefit from a one-on-one interaction based therapy such as PCIT.

PCIT has also been shown to be an effective tool within families with a history of both domestic violence and child maltreatment. Each year 5.3 million instances of domestic violence are reported and one in four women will experience some type of ill-treatment in her lifetime. Not only does the abuse create harm to the marital partner, but often children are either witnesses to the maltreatment or are themselves abused (Borrego, Gutow, Reicher, & Barker, 2008).

Although it may be unintentional, damage may also exist in the parent-child interaction that follows domestic violence issues. Issues that result from domestic violence include several types of behavioral and emotional problems which may manifest either externally or internally (McCloskey, McFarlane, Wilson, & Malecha, 1995). Children who are witnesses to domestic violence may become more aggressive and may display behaviors such as withdrawal, anxiety, and/or depression (Holden & Ritchie, 1991; Lemmey et al., 2001). According to Lemmey et al. (2001), these internalizing issues are directly correlated to the extent of abuse suffered by the mother.

Children may also develop anger issues as they are exposed to domestic violence. In a study of 40 children of various ages ($M = 11.1$) who had witnessed instances of familial abuse, it was discovered that boys were especially prone to more angry outbursts than children in the general population (Adamson & Thompson, 1998). Children who witness domestic abuse may also experience impairment in their social skills. In 2008 Borrego et al. discussed the rationale for the use of PCIT with parent-child dyads in domestic violence populations. According to the authors, many of the problems arising from the aftermath of familial violence are issues addressed through empirically supported interaction therapy such as PCIT (Borrego et al., 2008). For instance, it is thought that the quality of parenting is affected by a caregiver who has high levels of stress, impaired psychological functioning, and low social support (as is the case with

most abused partners in the domestic violence population). Due to their personal stressors, it is

also common for these parents to be less emotionally available to their children (Belsky, 1984).

High levels of unhappiness and depression are also prevalent in victims of domestic abuse which

may lead to inconsistent and ineffective parenting practices (Levendosky, Huth-Bocks, Shapiro,

& Semel, 2003). These studies indicated that a disruption occurs in positive parent-child

interaction as a result of domestic violence.

In 2010, Ramquist examined the efficacy of PCIT in domestic violence populations. Her

population included 62 child parent dyads from an inner-city child and family mental health

center. Data was collected pretreatment and at 10 and 20 weeks and focused on the parent's

behaviors, stressors, and perception of their child as well as the child's maladaptive behaviors.

Results revealed that the children's behaviors as well as the parenting behaviors and the parents'

levels of stress improved significantly over the course of training and data collection (Ramquist,

2010).

In a 2004 study, Chaffin et al. researched the relationship between PCIT and the

incidence of re-report of physical abuse among abusing parents. The study involved 110

physically abusive parents who were randomly assigned to one of three conditions: (a) traditional

PCIT, (b) PCIT plus individualized enhanced services (with particular attention to services

targeting parental depression, current substance abuse, and family, marital, or domestic violence

problems), or (c) a standard community-based parenting group. Participants had been involved

with the child welfare system in the past and had multiple abuse reports filed. Their behavior was

described as severely abusive toward their children. The parents also reported low income and

demonstrated depression, possible substance abuse, and antisocial behavior. At an 850 day

follow-up, 19% of the PCIT groups had a re-report of physical abuse compared to 49% for the

community based group. Those in the individualized enhanced services group did not show

improved behaviors compared to the traditional PCIT group (Chaffin et al., 2004). These

findings would indicate the value and effectiveness of PCIT training even in those repeat

offenders.

It is important to make every effort to improve the familial relationship. However, if

children are deemed at risk in their homes, removal may be necessary. In a 1998 study by

Clausen, Landsverk, Ganger, Chadwick, and Litrownik, 267 children aged 0-17 from three

California counties were studied to examine the effects of removal from the home on their

mental health. Data was collected through self-report measures (the Piers-Harris Children's Self-

Concept Scale) and through the Parent Report Form from the Child Behavior Checklist (CBCL).

The CBCL was usually completed by the foster mother. Their results indicated that 75-80% of

the children tested scored as either clinical or borderline on domains of social competence,

problematic behavior, or both. Even though demographics varied between the three county

agencies, results were similar across all measures. According to the authors, this similarity of

mental health issues among foster children was comparable to findings in other states and is

likely the result of a history of maltreatment combined with the negative effect of separation

from the family (Clausen et al., 1998).

Direct care staff that has contact with children removed from their home due to

maltreatment issues should benefit from instruction in an authoritative style of interaction. If

children have been exposed to a haphazard disciplinary method, they are more likely to engage

in oppositional/defiant behaviors once introduced into the child welfare system. Consequently,

those children who engage in aggressive and defiant behaviors may be placed in multiple homes

during their time in the child welfare system. This results in higher levels of both short and long term mental health issues for these children along with more strain on an already overtaxed child welfare system (Timmer et al., 2006).

      While PCIT had been widely studied in a variety of populations and circumstances, very few studies existed in which the relationship between maladaptive behaviors in children in a residential care setting is compared before and after caregiver instruction in an empirically supported interaction therapy. According to statistics from the Child Welfare League of America (CWLA, 2007), 500,000 children were in state custody in the United States as of 2007 and of those, more than 200,000 had been placed in residential group homes. In a move away from large institutions, more than 10,000 of these smaller facilities have developed in communities throughout the US. Typically, these homes are temporary shelter for children who have suffered varying levels of abuse and/or neglect. As such, most residents have been exposed to disorganized parenting and/or discordant interaction with their caregivers. A means of regulating interaction between child and caregiver in these situations should increase child compliance as well as boost staff morale. According to the CWLA (2007) one of the needs for change in the residential group home practice is minimal national standards for the care and treatment of residents. In an article in the Social Policy report, McCall (2009) made recommendations for the use of empirically supported programs. He suggested requirements for replicating evidence based practices. Among the recommendations were the use of previously evaluated programs, a description detailed enough to replicate, and faithful replication (McCall, 2009).

      Helping Hands Incorporated in Aiken, South Carolina is a residential care facility for children of all ages. According to the organization's 2013 Annual Report, ongoing care was provided by Helping Hands for children from birth up to 21 years of age who were removed

from their homes by South Carolina Department of Social Services or the South Carolina

Department of Juvenile Justice (Helping Hands, Inc., 2014). The average length of stay for the

residents was approximately 102 days but ranged from a few hours to three years under certain

circumstances. Residents of Helping Hands have been removed from their homes due to

incidents or history of abuse and/or neglect. As is typical for children in this situation, many have

complex problems and histories of family instability, abuse, neglect, and rejection. As a result,

many exhibit aggressive and/or defiant behaviors, and display depressive symptomology and/or

developmental delays (CWLA, 2007).

Hypotheses

The first hypothesis focused on the effectiveness of PCIT training in an institutional

setting. As evidenced by previous studies, PCIT has been proven to show improvement in the

behaviors and interactions of children with maltreatment histories as well as those who have

developmental concerns. It was hypothesized, therefore, that training in an empirically

supported interaction therapy such as PCIT would reduce instances of misbehavior among the

residents of the group home chosen for this research, Helping Hands, Incorporated. For this

study "misbehavior" was measured by the Eyberg Child Behavior Inventory (ECBI; Eyberg &

Pincus, 1999). The ECBI measures 36 behaviors such as dawdling, arguing, or refusing to obey,

verbal issues (e.g., arguing, sassing, or interrupting) and physical behavior (hitting, destroying

property, fighting, etc.). Ten items which were both observable and subject to change through

PCIT training were used to assess the efficacy of the current study. Items in the analysis

included "Argues with caretakers about rules", "Sasses adults", and "Physically fights with

fellow residents".

The second hypothesis concerned the level of Job Satisfaction of the caregivers involved in the study. In an environment such as the group home, job satisfaction is an important aspect in the daily functioning of staff members. As the misbehaviors of the children were hypothesized to have an effect on the overall job satisfaction of the caregivers, an indirect effect of PCIT was expected to be an increase in the rate of job satisfaction as measured by the Wellness Council of America Job Satisfaction Survey (Bellingham, 2008). More generally, job satisfaction was expected to have a negative relationship with child misbehavior.

The third hypothesis sought to measure the level of rigidity of the participants pre, during, and post intervention. The degree of rigidity in parents often coincides with perceived conduct problems in children. Given that the staff at Helping Hands fills parental roles, it was hypothesized that recorded levels of rigidity (as measured by the rigidity scale of the Child Abuse Potential Inventory, 2nd Edition/ CAPI-II) would decrease among direct care staff after training and use of PCIT skills. More generally, rigidity was expected to have a positive relationship with child misbehavior.

The final hypothesis proposed that an inverse relationship would exist between scores on the JSS and the CAPI. A higher level of rigidity was proposed to create a decrease in job satisfaction, therefore it was hypothesized that higher scores on the rigidity scale of the CAPI would negatively correlate with job satisfaction as measured by the Job Satisfaction Survey.

Method

Participants

Participants involved in PCIT training were five direct care staff at Helping Hands who worked with the younger population of residents (infant to age 12), as well as five children between the ages of 2 and 8. Adult participants, all of whom were African American women,

were randomly assigned a child in the residential program on whom to focus their five minute

play periods and data collection. Participants were asked to attend an informational session and

two PCIT training sessions representing required in-service at the workplace. Training was held

in the conference room on the Helping Hands campus. As this was a small and finite population,

a control group was not implemented.

Due to the low sample size in the intervention stage of the research, an additional sample

of participants was recruited to test hypothesized relationships between rigidity, job satisfaction,

and child misbehaviors. For the second group of participants, direct care staff, support staff and

volunteers who worked one on one with children in the facility were asked to complete the self-

report and child misbehavior measures described below. The data were collected during two in-

service meetings at the Helping Hands facility. A total of 28 staff participated. This sample

included 20 women and 8 men; eight were Caucasian and 20 African American. Those who

participated in the intervention phase of the study were not included in this sample.

To determine the number of participants required for sufficient power, the G*Power 3.1.7

calculator was employed. G*Power is a self contained power analysis program that can be

accessed online at no cost. It has been shown to be precise in measuring appropriate a priori

sample size in several test families (Faul, Erdfelder, Buchner, & Lang, 2009). Using a repeated

measures, within factors ANOVA and the following input: a one tailed test with an alpha level

set to $\alpha = .15$, power ($1\text{-}\beta$ probability of error) $= 0.8$, and an effect size of $\eta_p^2 = .06$, it was

determined that an appropriate sample size would be $n = 262$. The effect size was based on

inappropriate behavior data collected during a study conducted by Tiano and McNeil (2006).

Their research evaluated the use of PCIT as a means of behavior modification in Head

Start classrooms and included an experimental group of 4 classrooms and a control group of 3

classrooms. Their study concluded that, while change occurred in both the experimental and control groups, there was not a significant difference between the two outcomes (Tiano & McNeil, 2006). As the population of caregivers working with younger residents at Helping Hands, Inc. is reportedly numbered approximately 30; the experiment would be unlikely to achieve sufficient power with an effect size of $\eta_p^2 = .06$. With $n = 30$, actual power with the aforementioned effect size is estimated at 0.24.

In an attempt to improve the ability to detect significant change despite the acknowledged low power, the effect from PCIT training was determined by the use of a preselected subset of ten ECBI items. These were chosen based on their likelihood to change as a result of PCIT training. The experimental population, which consists of children who have been removed from their homes due to maltreatment, was also expected to increase the possibility of significance. In a typical population of young children, 10-15% exhibit problematic behaviors (Campbell, 1995). However, in children who have been removed from their homes greater instances of oppositional behaviors (50-61%) are evidenced (McNeil et al., 2005). It was presumed therefore that higher levels of change were more likely to take place in the population chosen for this study.

Procedure

The training and data collection adhered to the following schedule as outlined in Table 1. Session 1 (the informational session) involved discussion of the project and completion of informed consent for participants (see Appendix A). Consent and demographic information was also obtained through the legal guardian (the director of Helping Hands, Incorporated) for those children assigned to participate (Appendix B). Once consent was collected, the adult participants were asked to complete the pencil and paper self-report and child behavior measures described

below (Job Satisfaction Survey, Eyberg Child Behavior Inventory, and Child Abuse Potential

Inventory 2nd Edition) along with the Demographics survey (Appendix C). Participants were

instructed to focus their attention on their assigned child for the duration of training.

Session 2 took place one week later and involved training in the child directed portion of

PCIT which followed the PCIT for Caregivers' Manual (Appendix D). The manual is a slightly

modified version of the PCIT Guide Book written by Cheryl B. McNeil, Ph.D. and modified by

Beverly L. Fortson (recent modifications included changing the term "parent" to "caregiver" and

other minor alterations). Each participant was given a binder containing a copy of the

Caregivers' manual and other information. This first round of training involved instruction

through didactic and video representation and took approximately two hours. This included

instruction in the following 10 components.

1. A description of the goals of behavioral play therapy began the training. Participants were
   informed that this type of adult-child interaction helps to improve the child's self-esteem,
   increases attention span and is shown to decrease oppositional behaviors.

2. Discussion of the five minute daily practice sessions followed. The advantages of this
   short term play session were described as helping to reduce resistance to home practice
   by assuring that adults involved are able to keep the enthusiasm at a high level, since
   longer practices may have led to fatigue. In addition shorter periods of play time insures
   more cooperation by the child.

3. "Do" skills were then described and modeled. This involved a description of the PRIDE
   skills-praise, reflect, imitate, describe, and be enthusiastic-and discussion on how to use
   the skills to aid in compliance.

4. Presentation and modeling of "don't" skills followed. This included information on how best to interact with the child during play therapy. Adults were advised to not command or ask questions as these behaviors by adults tend to take away from the child's leadership. Participants were also asked to avoid any type of criticism as this time is meant to raise self-esteem and cooperation. Criticism may actually cause an increase some negative behaviors.

5. Discussion of using PRIDE skills for redirection followed. Participants were advised to use and follow worksheets and examples that were provided in their copy of the PCIT manual.

6. Discussion of strategic attention such as using the "do" skills to reward the child for appropriate behaviors also took place.

7. Selective ignoring was then described. Participants were advised to identify the specific, non-harmful behaviors they wished to decrease and use selective ignoring accordingly; adults were then cautioned that these behaviors may increase initially during the training as children sought to gain attention for their behaviors.

8. Modeling of skills in combination was then initiated. This involved description and demonstration of the individual skills used during PCIT.

9. Role play and coaching skills for participants followed which involved three 1-minute role plays with coaching.

10. Lastly, the logistics of play therapy in vivo was discussed which included the description of the ideal play area with imaginative play things (Hembree-Kigin & McNeil, 1995).

   Following CDI training, participants were asked to participate in daily five minute
playtime sessions with their assigned child using do and don't skills, selective ignoring and

strategic attention as discussed in CDI training and the PCIT Guide Book for a duration of two weeks (Sessions 3 and 4/weeks 3 and 4). A room on the Helping Hands campus was designated for use for these sessions as were specific toys (i.e., modeling clay, drawing supplies, building blocks, etc.) which were provided by the researcher. Participants were asked to record the days on which they participated in the five minute playtime each week along with any questions or concerns that might have arisen on the homework record form included in their binder (Appendix E). The researcher designated one day each week for the collection of this information and to answer any questions participants may have had. Following the two weeks of CDI practice, the CAPI-II, Job Satisfaction Survey, and ECBI were re-administered (during Session 4 at week 4).

The second two-hour phase of training took place three weeks following the initial training and replicated the Parent Directed Interaction (PDI) described in the PCIT literature using didactic, video, and role play demonstrations (Session 5). For clarification purposes during this study, this aspect of training will continue to be labeled Adult Directed Interaction (ADI). Instruction in ADI included the following seven components.

1. Explanation was given on the use of compliance exercises including the benefits of structure, consistency, and predictability in discipline.

2. Participants were then involved in a discussion on how to give effective directions. Instruction included guidance in using direct commands, stating those commands positively, making a single specific command at a time and using manners and a neutral tone of voice.

3. Discussion continued with information involving how participants could determine if the child had truly obeyed. This discussion included information on how to recognize if the

child was dawdling, doing something slightly different than what was requested, "playing

deaf", partially complying, minding with a bad attitude, or undoing.

4. Participants were then instructed on the use of praise for positive behavior, specifically

   the use of labeled praise when the child complied with an adult request.

5. Discussion continued with instruction on the consequences for disobeying. These

   included the use of time out and how to get the child to time out, the length of stay in

   time out and how to handle misbehaviors.

6. Instruction continued with the presentation of back-ups for time out. Participants were

   informed that, if the child were to leave time out before they were instructed to or if

   he/she engaged in risky behavior, the next disciplinary step could include isolation in a

   separate room or restriction of privileges.

7. Role play and coaching of discipline skills completed this phase of training. At this time,

   participants were given a role play review of the entire disciplinary procedure. (Hembree-

   Kigin & McNeil, 1995).

Following the training, participants were again asked to record occasions of use and any

questions they might have for the researcher (Appendix F). This homework was also collected

once a week on a designated day over a two week period (Sessions 6 and 7). The CAPI-II, JSS,

and ECBI were re-administered following the two week ADI practice (during Session 7). One

month following completion of training and in vivo practice, the measures were re-administered

a final time (Session 8).

Homework was collected once weekly during both the child directed and adult directed

intervention. Data indicated that participants were following the protocol introduced during

training (3-5 play sessions per week). Behavior management was implemented as needed. No issues were reported by the participants during the homework phase.

The second group of participants (28 staff in direct care and support positions) completed the pencil and paper self-report measures (Job Satisfaction Survey, Eyberg Child Behavior Inventory, and Child Abuse Potential Inventory 2nd Edition, Rigidity Scale). These measures were collected by the researcher on successive visits to the Helping Hands campus until data was obtained from all participants. Collection took place during an executive team meeting and then during an in-service involving all direct care staff.

Measures

Job Satisfaction Survey. Adapted from the Wellness Council of America Job Satisfaction Survey, the survey is a 30-item yes/no self-report measure that assesses the current level of job satisfaction (Bellingham, 2008; Appendix G). It evaluates this through questions such as: "I look forward to going to work on Monday morning", "I trust our leadership team", "I feel valued and affirmed at work", "My opinions count", and "Most interactions at work are positive". Yes answers are awarded two points and a scale determines whether the employee considers their place of employment: Extremely positive (50-60 points), Positive (40-48 points), Average (30-38 points), Below average (20-28 points), or Poor (2-18 points).

Eyberg Child Behavior Inventory (ECBI revised). The ECBI is a 36-item behaviorally specific rating scale that measures the current level of disruptive behaviors on a 7-point Intensity scale. It also measures the level to which parents or other caregivers consider those behaviors problematic on a "Yes" or "No" Problem scale and is also effective in identifying caregivers who may have behavioral expectations that are either too high or too low for the children in their care. The measure has been normed for ages 2-16. On the ECBI parents/caregivers are asked to rate

child misbehaviors on a scale ranging from 1(never occurs) to 7 (always occurs). An intensity score greater than 130 (T score of 60) or a problem score greater than 15 (T score of 60) indicates behavioral deviancy. This ECBI is an empirically sound measure that is recommended for use during PCIT training. According to the authors of *Parent- Child Interaction Therapy,* the ECBI is a measure that is "most responsive" to PCIT training and should be considered as an evaluative tool for the intervention (Hembree-Kigin & McNeil, 1995).

The ECBI takes approximately five minutes to administer and five minutes to score and has well documented validity (Eyberg & Pincus, 1999; Funderburk, Eyberg, Rich, & Behar, 2003). The ECBI has shown convergent reliability with the Child Behavior Checklist (which is also widely used during PCIT training); Problem Scale $r = 0.57$; Intensity Scale, $r = 0.71$ (Gross et al., 2007). Additionally, the reliability of the Intensity Scale and the Problem Scale ($\alpha=.94$ and $\alpha=.92$ respectively) have been shown to be significant (Gross et al., 2007) Revisions to the measure included the substitution of "caregivers" for "parents" and "other residents" for "siblings". General content was not modified. A preselected subset of 10 items likely to be altered by PCIT training was used to assess the significance of the experiment. Examples of items used included "Interrupts", "Verbally/physically fights with fellow residents", and "Refuses to obey until threatened with punishment". These items were also determined to be more generalizable for use in the varied child population at the residential facility. For instance, some items on the ECBI may be developmentally appropriate for the younger aged children in the facility ("Whines", "Has poor table manners") while other items may point to behaviors of older children ("Steals").

In additional testing of the PCIT data, it was discovered through Cronbach's alpha that internal consistency was not present within each time of collection. Time 1 yielded an alpha of

α = .84 which translated to a high level of internal consistency, Time 2 recorded α = .50 (poor

internal consistency) and Times 3 and 4 generated negative alpha scores (α = -2.8 and α = -.50

respectively) which is indicative of a lack of internal consistency.

Child Abuse Potential Inventory, 2nd Edition (CAPI-II). The CAPI-II is a 160 item

self-report inventory developed in 1976 as an easy to use, objective screening device for

detecting the potential for child abuse. The measure has been used in clinical settings and as a

research tool to compute the potential for child abuse and has shown to be useful in

distinguishing between non-abusive and previously abusive parents (Laulik, Allum, & Browne,

2013). According to Heinz and Grisso (1996), the CAPI is one of the most widely used tools for

determining potential abuse in Child Protective Services. The measure contains ten scales

including rigidity, unhappiness, problems with child and self, family, or others, and distress. The

rigidity scale is a 14 item subset of items which record the inflexibility of attitudes toward

children's behavior and appearance and is useful in detecting those who may be forceful in

attempting to fit children into a predetermined mold. Examples include "Children should never

disobey", "A home should be spotless", and "A child needs very strict rules". The CAPI-II

Abuse Scale shows construct validity with the MMPI Social Introversion-Extraversion Scale (r =

.63) and the Parenting Stress Scale (r = .51). The CAPI-II has high internal consistency across

abuse groups (α = .95-.98) as well (Milner, 1980). For the purpose of this study, only the rigidity

scale was implemented. According to a study by Milner and Wimberley (1980), rigidity was

among the most meaningful dimensions in understanding why children are abused. As rigidity is

a trait that is more constant over time than the other major dimensions mentioned as most

relevant in their research (unhappiness and distress), it was determined to be the best choice for

the current study population (Milner & Wimberley, 1980). Laulik et al. (2013) also determined

that the rigidity scale (along with the Distress scale) had higher internal consistency than other

subsets of the CAPI.

Results

Data collected was entered into and analyzed using the Statistical Package for the Social

Sciences (SPSS). PSPP, a free software offered by GNU/Linux, was also implemented.

Significance was set at an alpha level of .05.

Changes in Child Misbehavior

In order to examine the first hypothesis which proposed that training in PCIT would

reduce instances of misbehavior among the residents of the group home a repeated measures

analysis of variance (ANOVA) tested the levels of child behavior problems as measured by the

ECBI before training in PCIT (Time 1), during training in PCIT (Times 2, Time 3) and during a

one month follow up (Time 4). This involved one categorical independent variable (Times 1

through 4) and one continuous dependent variable (level of misbehaviors of children as

measured by the ECBI).The means and standard deviations of the 10 item subset of the ECBI

can be viewed in Table 2. This data was collected during the intervention in which five direct

care staff members participated. No significant effect was observed, $F(3, 12) = .69$, $p = .58$, $\square^2 =$

.15. Figure 1 represents the overall means and T scores earned by the individual children through

the application of the ECBI. A T score of 60 represents the cutoff for clinical significance on the

ECBI (Eyberg & Pincus, 1999). In the sample, Child 1 shows behavior at clinical levels at each

data collection point (T = 67, 68, 65, and 64). Child 3 began the intervention at a clinically

significant level (T = 60) but showed reduced levels at subsequent data points. The scores of the

three other children stayed below clinical significance throughout the intervention.

Job Satisfaction

The second hypothesis predicting that job satisfaction rates would improve after staff members were trained in PCIT skills was tested with a one way repeated measures ANOVA. Data was collected from five direct care staff who worked with the younger population of children in the facility. The ANOVA measured the levels of job satisfaction before training in PCIT (Time 1), during training in PCIT (Times 2, Time 3) and during a one month follow up (see Figure 2). The means and standard deviations from the four data collection times are documented in Table 2. Significance was noted, $F(3, 12) = 3.4$, $p = .05$, $\eta^2 = .46$. A partial eta squared of .46 would indicate a medium effect. Although the means of job satisfaction remained equal from Time 1 to Time 2 ($M = 51.2$), a gradual increase was noted between Time 2 and Time 3 ($M = 54$) and again between Time 3 and Time 4 ($M = 55.6$).

A Pearson product-moment correlation coefficient using the larger population of added participants assessed the relationship between perceived childhood misbehaviors via scores on the ECBI and the participant's satisfaction with their job at the facility. There was a nonsignificant positive correlation between the two variables, $r(28) = .16$, $p = .41$.

Rigidity

The levels of rigidity (as measured by the rigidity scale of the Child Abuse Potential Inventory, 2nd Edition/ CAPI-II) were examined using a repeated measures analysis of variance (ANOVA). Scores from the four data collection times were used (see Figure 3). Means and standard deviations are noted in Table 2. Analysis showed that the relationship was marginally significant, $F(3, 12) = 3.6$, $p = .05$, $\eta^2 = .47$. A medium effect size was recorded. Rigidity increased slightly from Time 1 ($M = 22.2$) to Time 2 ($M = 22.6$) but decreased from Time 2 to Time 3 ($M = 16.8$) and again from Time 3 to Time 4 ($M = 15.0$).

The relationship between child misbehaviors (as recorded by the ECBI) and the participants' rigidity (as measured by the rigidity scale of the CAPI) was examined using correlational analyses. A positive, significant correlation was found, $r(28) = .52$, $p < .01$, which indicated that higher levels of rigidity were associated with elevated levels of perceived childhood misbehaviors.

Rigidity and Job Satisfaction

A Pearson product-moment correlation coefficient was computed to evaluate the relationship between rigidity scores (via the CAPI) and job satisfaction as measured by the Job Satisfaction Survey (JSS). There was a negative correlation between the two variables, $r(28) = -.23$, $p = .25$, however, no statistical significance was noted.

Discussion

The goal of this study was to improve adult interactions with the children in their care at a residential care facility for children with maltreatment histories. It was also proposed that an increase in job satisfaction and a decrease in adult rigidity and child misbehavior would occur after instruction in Parent-Child Interaction Therapy (PCIT). The intervention phase of the study evaluated the efficacy of PCIT in a residential facility for children with maltreatment histories. Due to the incidence of higher levels of misbehavior in children who have suffered abuse and/or been removed from their homes (McNeil et al., 2005), it was theorized that creating a positive style of adult-child interaction through training caregivers in an empirically supported therapy would reduce instances of misbehavior. With the reduction of misbehaviors it was also theorized that direct care staff would experience an increase in job satisfaction and a decrease in levels of rigidity.

Results did not support the hypothesis that training in PCIT would reduce instances of misbehavior. Neither did correlations between child misbehaviors with job satisfaction and rigidity with job satisfaction yield statistical significance. Training in PCIT was associated with increased job satisfaction however, along with decreased rigidity levels in direct care staff. Also, statistically significant relationships were found between perceived childhood misbehavior and caregiver rigidity.

While the expectation was that childhood misbehaviors would decrease after the introduction of PCIT, it actually increased as the training was being implemented. There are several reasons why PCIT training may not have resulted in declines in children's misbehaviors: lack of reliability, increased salience of the misbehaviors, or the initial low levels of misbehaviors by targeted children. The absence of reliability according to Cronbach's alpha is troubling. The lack of reliability might indicate that participants may not have taken the time to thoroughly read through the questionnaire before responding. Environmental factors might have affected the reliability of the measure in these instances. Respondents may have been distracted by other tasks or they may not have felt motivated to complete the survey reliably. It is possible that the ECBI highlighted behaviors that had not been noted previously. Thus, scores showed an increase after training and explanation of the measure due to participants' new awareness of a variety of behaviors. Although children who have been removed from their homes due to maltreatment typically record significantly higher numbers of maladaptive behaviors (which was expected to increase the possibility of significance) only two of the children in the study recorded scores in the clinically significant range.

Although the childhood misbehaviors were not reduced overall during the intervention phase of the research, job satisfaction increased throughout the study and rigidity levels

decreased as the participants took part in the implementation of PCIT. The introduction of an interaction and disciplinary methodology may have added to job satisfaction while helping to decrease rigidity by giving the direct care staff a means by which to regulate and measure their interactional style with the children in their care. Often parents and those filling parental roles (as do direct care staff) view children's apparent misbehaviors as defiance (Asawa et al., 2008). Being instructed in PCIT would have allowed them an alternative view of the behaviors of the children in their care.

Correlational examination of the relationship between the ECBI, CAPI and JSS measures did not support the hypotheses that higher rigidity scores would negatively correlate with higher JSS scores or that staff members who reported their assigned child as higher in misbehaviors according to the ECBI would also have a lower score on the Job Satisfaction Survey. The high average of job satisfaction scores may have been the cause of this lack of correlation. Job satisfaction scores were extremely elevated throughout data collection. These consistently high scores did not allow for variance in the data collection.

The hypothesis that higher rigidity scores would positively correlate with higher scores on the ECBI did show statistical significance however. In general the results indicated that those participants with higher levels of rigidity as measured by the rigidity scale of the Child Abuse Potential Inventory (CAPI) also scored higher on the Eyberg Child Behavior Inventory (ECBI). This result is not surprising as the measures discuss similar items' the ECBI measures behaviors specific to an individual child such as "Acts defiant when told to do something" while the CAPI records an adult's perceptions of misbehaviors i.e., "Children should never disobey".

Limitations

The results of the intervention phase of this study were limited initially by the low number of participants ($n = 5$). As sample size is a major determinant of the power of analyzed data, it may be inferred that a larger sample would produce a greater power. Since the means of the data were beginning to trend in the expected direction, it can be theorized that, with a larger number of participants, the intervention would have been more valid and statistical significance would have been hardier across all hypotheses.

Another limitation in the current research involved the length of training in Parent-Child Interaction Therapy (PCIT). Typically, PCIT takes place over 14-16 sessions and includes one-on-one didactic training, coaching sessions in vivo for both CDI and PDI, and follow-up and booster sessions (as needed). The current intervention used an abbreviated version of PCIT. In this instance, the intervention was administered over two training sessions, in CDI (Week 2) and PDI/ADI (Week 5). Data collection took place over six additional weeks during the intervention phase of research. There was no direct coaching of the participants in vivo (Eyberg, 2010). Results failed to support the efficacy of the intervention in reducing child misbehaviors. In this series (hypothetical reduction of childhood misbehaviors), instances increased one point from Time 1 to Time 2 and another 4.2 points between Time 2 to Time 3. Misbehaviors began to decrease at Time 4 (a 3.4 point reduction) but did not show an overall decrease during the intervention. The lack of internal consistency of the ECBI data would indicate that participants were not always attentive in their responses. The amount of contact between the researcher and the participant population in this study was limited by the availability of the direct care staff in the facility and time constraints of the researcher. A more thorough training of the participants might have benefited the research.

The wide range of children included in the study (children ranged from age 2 through ages 8) might also be considered a limitation. As the ECBI measures a variety of behaviors, the age of the child would have affected the reporting on the measure. Some behaviors for instance that would typically be deemed inappropriate at higher ages (e. g. whining or bed wetting) might not be recorded as problematic at younger ages. The reverse would also be expected. Although the complete ECBI was administered, a 10 item subset was used for analysis of the hypotheses.

Furthermore, this study involved only self-reported data. As such, the results cannot be verified beyond doubt. The researcher must take the word of participants and believe that they have answered accurately and truthfully. Studies which have used observational data along with the self-report measures have been shown to create higher levels of correlation than those which used self-report data alone (Lyon et al., 2009). The current study might have recorded higher levels of correlation if observational data were included.

As one of the measures dealt with job satisfaction and was recorded while participants were at work, these results may be skewed. It may have benefited the research to place more emphasis on the idea of confidentiality of the information collected. The Job Satisfaction assessment was extremely high in most instances during the study. This may have been the result of fear of discovery or reprisal by supervisors or coworkers.

Another limitation was the lack of prior research into the specific criteria of the current study. Although PCIT has been empirically supported in a variety of venues, its instruction to a group of direct care staff in a residential facility had not been recorded at the time of this study. It would have been helpful to have been able to refer to data and methodology from previous studies before this research began.

Strengths

Although not all hypotheses were proven significant the current study showed some promise. Even though the introduction of Parent-Child Interaction Therapy (PCIT) did not lead to improvement in childhood misbehaviors as hypothesized, small changes were seen in both job satisfaction and rigidity levels during the intervention phase of the research. Correlational data in the larger population also showed significance between rigidity and childhood misbehavior. Also, the introduction of PCIT in an institutional setting during this study was a novel use of the intervention.

General Conclusion and Future Directions

The use of PCIT in a residential care facility for children with maltreatment histories is worthy of replication. Children who have been removed from their homes and placed in group residential settings are at risk for higher levels of oppositional defiant behavior (McNeil et al., 2005). Another risk factor for childhood maladaptive behavior is disorganized parenting (Baumrind, 1967). Since direct caregivers in facilities, such as Helping Hands, Inc. fill parental roles, it would benefit the residents to have an organized system of child-adult interaction. The results may show more significance if data were collected from several like agencies thus increasing the participant pool.

Different measures might also be used. The authors of *Parent-Child Interaction Therapy* have several recommended assessments that are viable options for use with PCIT training. They mention several core procedures that might be used including the Child Behavior Checklist and the Parenting Stress Index. They also note supplemental assessments that might be used (Hembree-Kigin & McNeil, 1995).

Future research should implement PCIT in its entirety. With the completion of the 14-16 week program which includes coaching and more long term, elaborate data collection, the participants and researcher would have more contact thus ensuring more in depth informational exchange. Results would also be more meaningful with complete PCIT training since participants would have been given the full benefit of training. Furthermore, since the assessments were all self-reports, it may also aid future research by meeting with participants one on one to collect data to give instruction and answer any questions that may arise.

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Table 1

Details of training and data collection sessions

Week 1	Week 2	Week 3	Week 4
Information session CAPI-II, JSS, ECBI	Group training in Child Directed Interaction (CDI)	CDI homework collection	CDI homework collection CAPI-II, JSS, ECBI
Week 5	Week 6	Week 7	Week 10
Group training in Adult-Child Interaction (ADI)	ADI homework collection	ADI homework collection CAPI-II, JSS, ECBI	CAPI-II, Job Satisfaction Survey, and ECBI

Table 2

Means and Standard Deviations of Data Collected During Intervention

	Time 1		Time 2		Time 3		Time 4				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*df*	*F*	□2
ECBI	56.2	4.62	57.2	4.98	61.4	2.38	58.0	3.05	3	.69	.15
JSS	51.2	4.38	51.2	6.72	54.0	3.16	55.6	2.19	3	3.44	.46
CAPI	22.2	17.28	22.6	15.60	16.8	14.34	15.0	20.0	3	3.58	.47

Note: Means are raw score means. ECBI scores are derived from a subset of ten items.
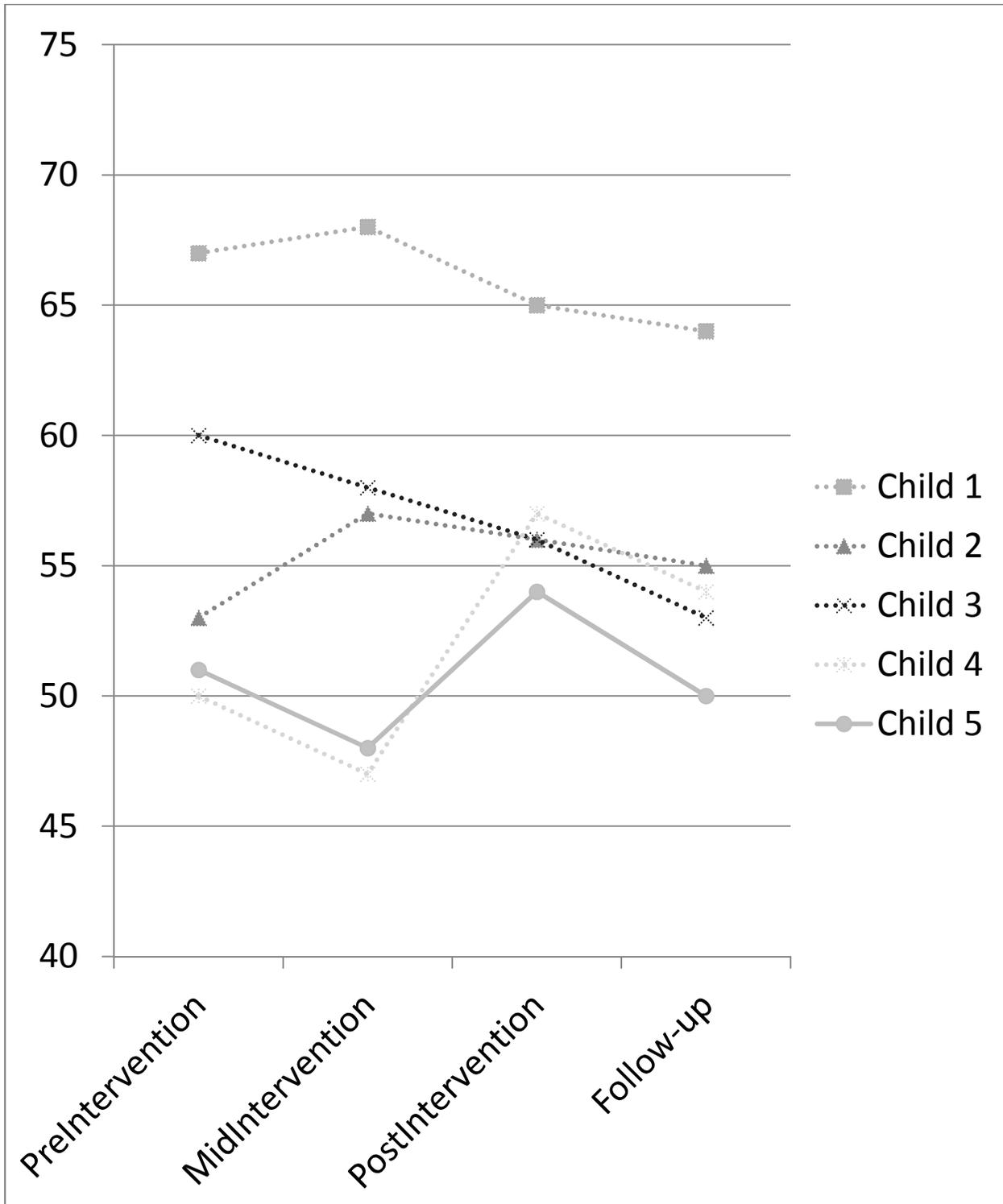
Figure 1. Individual children's T scores from ECBI intensity scale
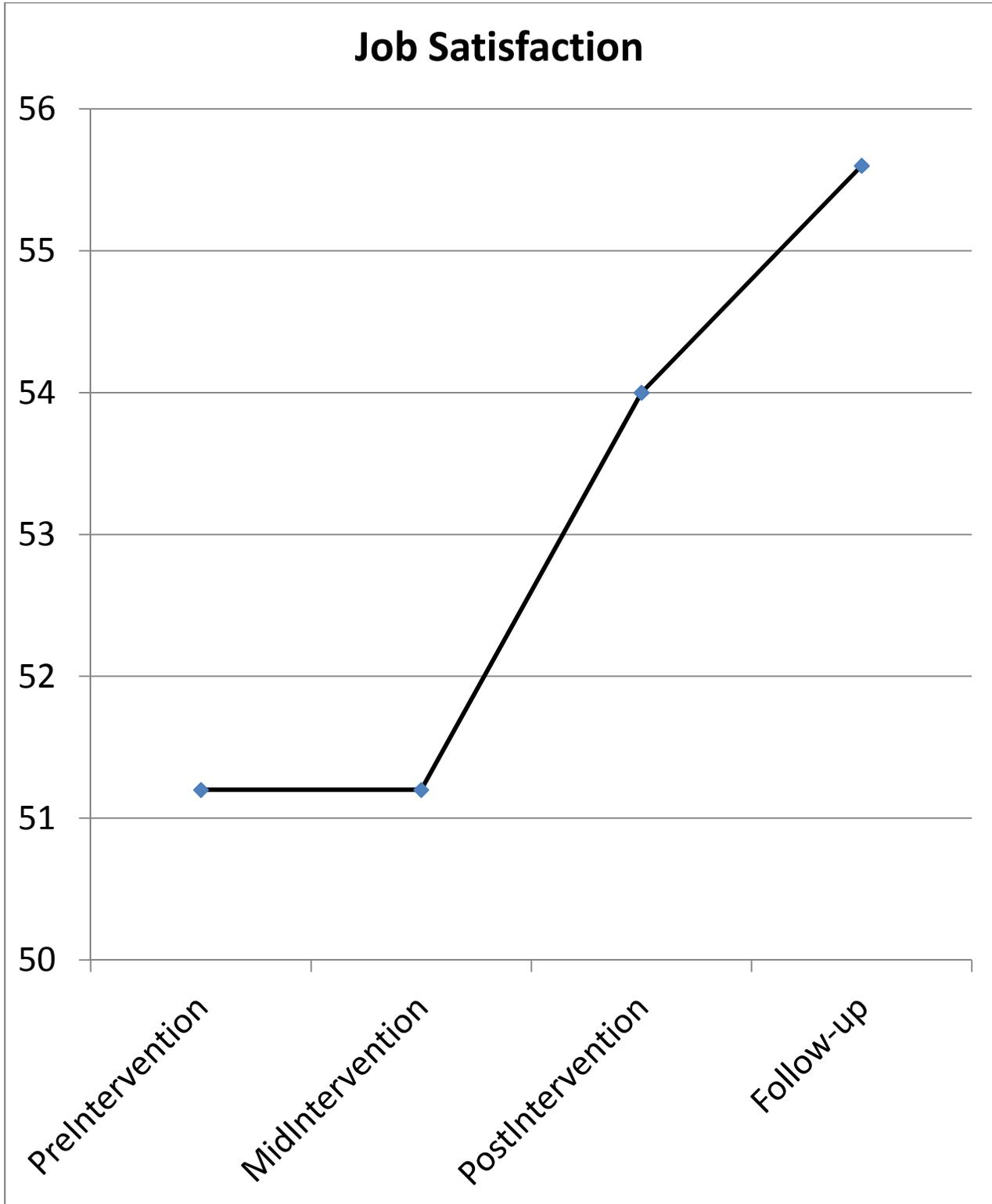
Job Satisfaction

Figure 2. Overall means of Job Satisfaction during intervention stage
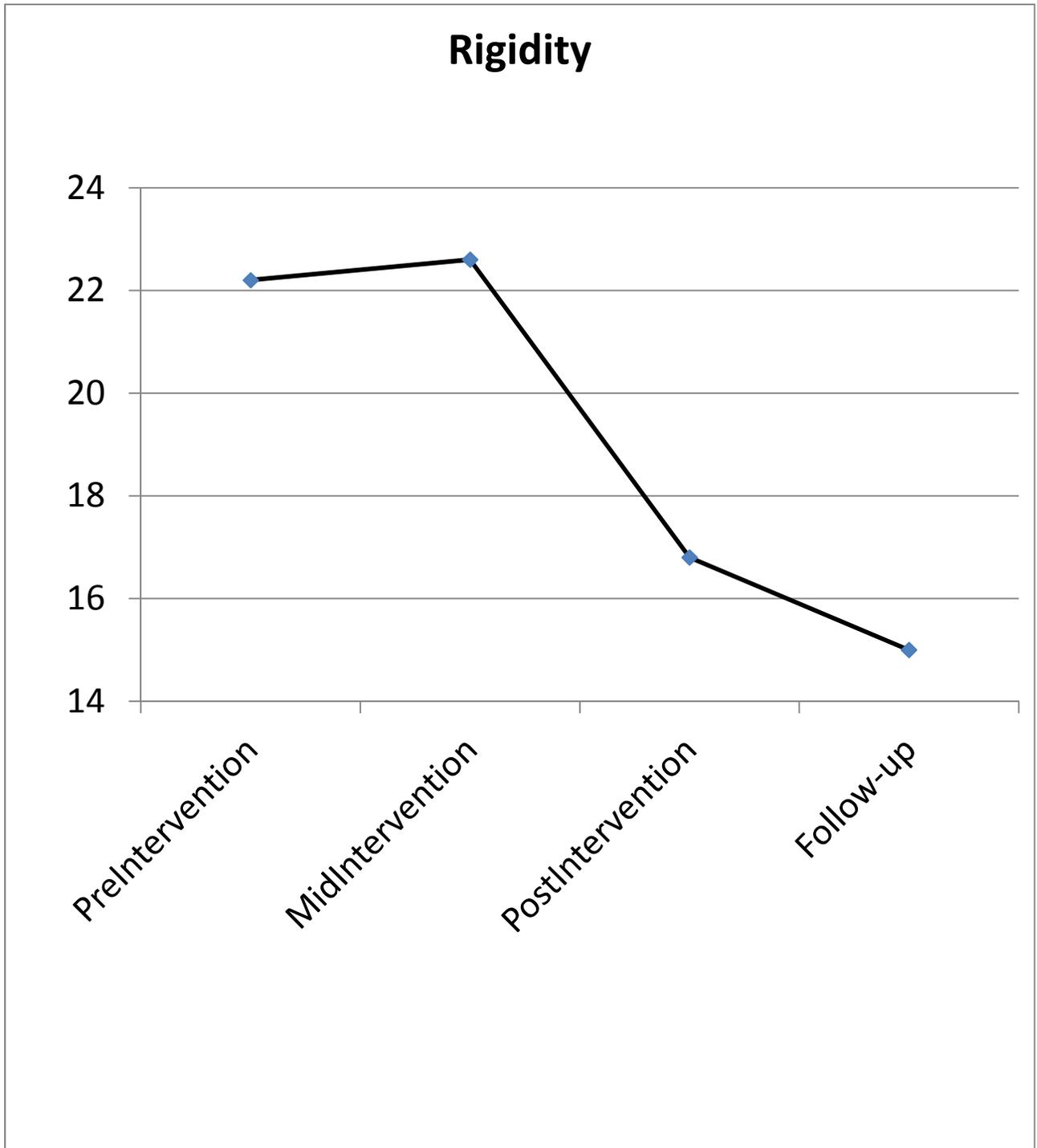
Figure 3. Overall means of rigidity levels during intervention stage

Appendix A

UNIVERSITY OF
SOUTH CAROLINA
AIKEN

Participant Informed Consent Form

You are scheduled to participate in a research study investigating the effects caregiver-child interaction therapy on child misbehaviors, adult expectations of childhood behaviors and appearance, and job satisfaction. This experiment is being conducted by Victoria Riley to fulfill requirements for a master's degree at the University of South Carolina Aiken. Dr. Sarah Stevens is the faculty supervisor for this study.

Your participation in this study will involve completing training in an empirically supported method of child-adult interaction originally known as Parent-Child Interaction Therapy or PCIT. PCIT has been studied and implemented for more than three decades and has been shown to effectively decrease childhood misbehaviors and increase positive Adult-Child interactions in a variety of populations (Preschool classrooms, foster families, oppositional and/or defiant children, and one-on-one with parents, teachers or other caregivers). Throughout the experiment you will be asked to complete self-report measures as well as use the skills learned in order for data to be collected.

Although you will not be at physical or psychological risk it is possible that participation in this research may cause you to feel temporarily anxious or nervous. If you wish to stop your involvement at any time, you may do so without any repercussions. You may simply tell the experimenter that you wish to quit, and the study will be stopped. The experimenter will assist you in completing the various parts of the experiment; no "surprises" will be presented to you.

The information gathered during this experiment will be coded in a way that your name will not be revealed. The researchers will be the only people that have access to this information. The information will be combined and analyzed and will be kept strictly confidential.

If you have any questions about this research, you may contact:

      Victoria Riley, B.A.   (803) 641-3775 (O), (803)257-1480 (cell)
      (vtriley@usca.edu)
      Sarah Stevens, Ph.D.   (803) 641-3219 (O)

I have read this consent form and been given the chance to ask questions. If requested, I will also be given a copy of this form for my records and future reference. I agree to participate in the research described above.

_____   _____
Participant Signature   Date

_____   _____
Experimenter Signature   Date

Appendix B

Minor Child Consent Form

       You are the guardian of a child scheduled to participate in a research study investigating the effects caregiver-child interaction therapy on child misbehaviors, depressive symptoms and job satisfaction. This experiment is being conducted by Victoria Riley to fulfill requirements for a master's degree at the University of South Carolina Aiken. Dr. Sarah Stevens is the faculty supervisor for this study.

       Throughout the experiment the child will be involved in interactions with an adult caretaker being trained in an empirically supported method of child-adult interaction.

       Although there will be no physical or psychological risk it is possible that participation in this research may cause temporarily anxiety or nervousness. If you wish to stop the child's involvement at any time, you may do so without any repercussions. You may simply tell the experimenter that you wish to discontinue the child's participation, and their involvement in the study will be terminated.

       The information gathered during this experiment will be coded in a way that neither your nor the child's name will be revealed. The researchers will be the only people that have access to this information. The information will be combined and analyzed and will be kept strictly confidential.

If you have any questions about the child's participation in this research, you may contact:
       Victoria Riley, B.A.   (803) 641-3775 (O), (803)257-1480 (cell)
       (vtriley@usca.edu)
       Sarah Stevens, Ph.D.   (803) 641-3219 (O)

I have read this consent form and been given the chance to ask questions. If requested, I will also be given a copy of this form for my records and future reference. I agree to allow the child in my care to participate in the research described above.

_____   _____   _____
Child Name   Age   Date

_____   _____
Guardian Signature   Date

_____   _____
Experimenter Signature   Date

       Date of entry into the facility _____

Appendix C

Demographic Questionnaire

Please complete the following information. DO NOT PUT YOUR NAME ON THIS FORM.

1. Male_____   Female_____

2. Age_____

3. Race_____

4. Job Title_____

5. Years with current employer_____

Appendix D

PCIT Training
Helping Hands, Inc.
Aiken, SC

A Guide Book Written By:
Cheryl B. McNeil, Ph.D.
West Virginia University

Modifications by:
Beverly L. Fortson, Ph.D.
University of South Carolina-Aiken

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UNDERSTANDING MISBEHAVIOR

Theory of Optimal Stimulation

- There exists for all humans a biologically determined optimal level of stimulation.
- When the level of stimulation needed is not present, activity can serve as a means to achieve an optimal level of arousal.

APPLICATION TO TYPICAL INDIVIDUALS

1. *Sensory Deprivation = Stimulus Seeking*
   People tend to engage in stimulus seeking behavior when their arousal needs are not met. For example, if someone has had a slow and boring day, that person will be more eager to go out and do something fun.

2. *Sensory Overload = Stimulus Avoidance*
   People tend to restrict activity and avoid stimulation when their arousal needs are met. For example, when someone has had a stressful and frantic day, that person will likely seek relaxing activities, such as watching T.V. or reading a book.

CHILDREN WITH ADHD

1. Children with ADHD behave as if levels of stimulation optimal for other children are insufficient for them. ADHD children constantly dip into states of underarousal.

2. When ADHD children are in high-stimulation settings, they cannot be differentiated from other children. These settings include playgrounds and places with video games.

3. ADHD children engage in "behavioral accommodations" when they are in states of underarousal. These accommodations include high levels of activity, such as getting out of their seats and humming to themselves.

4. Increased activity in low-stimulation environments facilitates an optimal level of arousal for children with ADHD.

Psychostimulant Medication

Methylphenidate, more commonly referred to as Ritalin, has been used for well over 20 years in this country. It is one of five psychostimulant medications which are commonly prescribed for the treatment of hyperactivity. The other four drugs are Adderall, Concerta, Dexedrine (dextroamphetamine) and Cylert (permoline). Although the drugs differ in some ways, each of them act to stimulate the nervous system and in doing so help children to filter distractions, learn better, and appear calmer.

Because research has not yet determined the long-term effects of prescribing psychostimulant medication to young children, it should be used sparingly. The use of medication can produce

adverse, long-term consequences, particularly when used with young children while their brains are still developing. Another consideration is that medication should only be prescribed when there is a neurological problem. Many times oppositionality and hyperactivity can be caused by problems in the home. Therefore, before a child is treated with psychostimulant medication, the cause of the problem should be assessed.

Why Children Misbehave

There are a number of reasons **why** children misbehave, which are important when determining how to handle the misbehavior. Children may misbehave to get attention, to get something, to get out of something, or to stimulate themselves.

To Get Attention

Acting silly during quiet time, repeatedly yelling the caregiver's name.

To Get Something

Grabbing toys from other children, coloring the flower green instead of yellow after being asked to color it yellow (get control)

To Get Out of Something

Refusing to clean up, refusing to leave the playground

To Stimulate Themselves

Knocking Legos over, running around the room

PREVENTING MISBEHAVIOR"
P.R.I.D.E. skills to be used during Child Directed Interaction

"**P**   R   I   D   E"

Do **Praise** appropriate behavior.

All **praise** is good for the child's self-esteem and for building rapport between the adult/ caregiver and the child. For increasing appropriate behavior, however, **labeled praises** are much more effective than **unlabeled praises.**

Unlabeled praise is global and nonspecific.

Examples: "Great!"   "Nice job!"   "Good boy!"   "Thanks for behaving."
"Terrific!"   "I'm so proud of you!"   "You're terrific!"

Labeled praise tells the child specifically what you like about his or her behavior. Once the child knows exactly what you like, he or she is more likely to do it again.

Examples: "Nice job of putting the toys away!"   "Good boy for sitting up straight!"
"I'm so proud of you for sharing with the other children!"

Rule	Reason	Examples
Do **Labeled Praise** for appropriate behavior.	Causes the behavior to increase Lets the child know what you like Increases self-esteem Adds to warmth of the relationship Makes both adult/caregiver and child feel good!	Terrific counting! I like the way you're playing so quietly. You have wonderful ideas for this game. I'm proud of you for being polite. You did a nice job on that building.

Exercise
PRAISE THE OPPOSITE

To manage problem behaviors using labeled praise, find a behavior that is the exact **opposite** of the problem behavior. Then, be on the look-out for the opposite behavior, and give an enthusiastic labeled praise whenever you notice it.

PROBLEM BEHAVIOR	OPPOSITE BEHAVIOR	LABELED PRAISE
1. Defiance	Minding	Thank you for minding right away.
2. Biting	Playing gently with other children.	Good job of playing gently with the other children.
3. Whining	Talking in a "big boy" voice.	I like it when you talk like a big boy.
4. Screaming		
5. Leaving the playground		
6. Banging on the fish tank		

7. Climbing on furniture

8.

9.

10.

What if Praise Doesn't Work?

There are a couple of reasons why praise may not work for all children. In fact, some children will actually <u>misbehave</u> after being praised.

> Example: (Adult/Caregiver): "I like the way that you are coloring inside the lines!"
> (Child):   (Scribbles all over the paper.)

This behavior usually happens because the child is seeking **more** attention.

> Example: (Adult/Caregiver): "I like the way that you are coloring inside the lines!"
> (Child):   (Scribbles all over the paper.)
> (Adult/Caregiver): "Now why did you have to go and do that!" "I can't say anything nice to you!"

In this example, the child received **more** attention for <u>misbehaving</u> than he or she received for <u>behaving appropriately</u>. It is very important to **<u>under-react</u>** to annoying or obnoxious misbehavior to reduce this attention-seeking.

Another consideration is that children who misbehave after being praised may be <u>unaccustomed</u> to being praised and need <u>time</u> to get used to it.

Our recommendation is to continue to use praise. It may take some time, but eventually it should work.

"P **R** I D E"

Do **Reflect** appropriate talk.

A **reflection** is a statement that repeats back what the child just said. The statement may be <u>extended, elaborated, or shortened.</u>

Example:	(Child):	"I put the sticker on the chart."
	(Adult/Caregiver):	"Yes, you put the blue sticker on the chart all by yourself!"

Rule	Reason	Examples
Do **Reflect** appropriate talk.	Doesn't control the conversation Shows child you're really listening Demonstrates acceptance and understanding Improves child's speech Increases verbal communication	Child: I made a star. Adult: Yes, you made a star. Child: The camel has bumps on top. Adult: It has two humps on its back. Child: I like to play with this castle. Adult: This is a fun castle to play with.

"P   R   **I**   D   E"

Do **Imitate** appropriate play.

Imitation is playing with the same or a similar toy and attempting to manipulate the toy in a way that is close to what the child is doing.

Example:	(Child):	(Rolls blue Play-Doh into a hot dog.)
	(Adult/Caregiver):	(Picks up some yellow Play-Doh and begins rolling it into a hot dog.)

Rule	Reason	Examples
Do **Imitate** appropriate play.	Lets child lead Approves child's choice of play. Shows child you are involved Shows child how to play with others (forms basis of taking turns)	Child: I'm putting baby to bed. Adult: I'll put sister to bed too. Child: I'm making a sun in the sky Adult: I'm going to put a sun in my picture, too.

"P   R   I   **D**   E"

Do **Describe** appropriate behavior.

A **description** is a statement saying <u>exactly</u> what the child is doing. It is giving a <u>play-by-play</u> of what the child's hands are doing. **Descriptions** can be used to describe the child's appropriate behavior <u>before</u> misbehavior occurs.

Example:	(Child):	(Building a car with Legos.)
	(Adult/Caregiver):	"You're building a car. You put the blue Lego next to the green Lego."

Rule	Reason	Examples
Do **<u>describe</u>** appropriate behavior.	Allows child to lead Shows child you're interested Teaches concepts Models speech Holds child's attention Organizes child's thoughts about play	That's a red block. You're making a red tower. You drew a smiley face. The cowboy looks happy.

"P   R   I   D   **<u>E</u>**"

Do use **<u>Enthusiasm</u>**.

Enthusiasm is "<u>sudden changes</u> from rapid excited speech to a whisper, good eye contact and <u>variations</u> in expression; <u>quick</u> and demonstrative movements of the body, head, arms, and face; large body movements; vibrant, demonstrative facial expressions with quick and sudden changes…and an overall <u>high energy level</u>" (Burts, McKinney, and Burts, 1985, p. 22). **Enthusiasm** keeps children more <u>attentive, interested, and responsive</u>.

Example:	(Child):	(Playing with Mr. Potato Head.)
	(Adult/Caregiver):	"Wow! You put the eyes on Mr. Potato Head! You're doing a great job playing gently with Mr. Potato Head! I think I'll put the hat on Mr. Potato Head!"

Rule	Reason	Examples
Do use **<u>Enthusiasm</u>**.	Keeps the child interested. Helps to distract the child when ignoring.	Voice is playful with lots of inflection.

REDUCE YOUR USE OF THESE SKILLS

<u>REDUCE RAPID-FIRE QUESTIONS</u>

Avoid asking so many questions that you do not provide the child with an <u>opportunity to answer</u> them. Save your questions for those that will help to <u>teach a concept</u> or help to <u>obtain information</u>.

> Avoid this type of interaction: "Where's Mr. Potato Head going? Does he have a name? What is his name? Do you know? Is he going to the park?"

<u>REDUCE SUBTLE CRITICISMS IN THE FORM OF "NO," "DON'T," "STOP," "QUIT," AND "NOT"</u>

Instead of telling a child what she's doing <u>wrong</u>, try to point out what is <u>right</u>. So, instead of telling a child to "stop running," tell her what to do instead, "walk please." If a child holds up a green crayon and says, "Here's a blue crayon," avoid saying, "That's not blue." Instead, tell him what's right by saying, "That's a green crayon." In this way, you can correct children in a positive way. You also can avoid criticism by using ignoring and redirecting. When the child engages in a more positive behavior, you can provide a labeled praise.

Information on the PRIDE skills was taken from the following book:

Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-child interaction therapy.* New York: Plenum.

Adult Directed Interaction:

MANAGING MISBEHAVIOR

Misbehavior can be classified into two categories: misbehavior that is annoying or obnoxious and misbehavior that is dangerous or destructive. **Annoying or Obnoxious Behavior** is any behavior that will <u>not</u> potentially cause harm to anybody and includes such behaviors as whining, crying, mocking others, etc. On the other hand, **Dangerous or Destructive Behavior** is any behavior that has the potential to physically harm someone or something. For example, hitting a peer, throwing an art project, or repeatedly not doing what an adult requested are considered to be dangerous or destructive behaviors. Because of the differing levels of severity for these behaviors, they should be handled differently.

Managing Annoying or Obnoxious Behavior

REDIRECTION

Redirection is a way to get a child back on task. It can be used with <u>all</u> of the <u>"PRIDE"</u> skills, with <u>groups</u>, and with <u>fun, incompatible commands</u>.

Redirection using "PRIDE" Skills

Redirection using Praise

If a child is exhibiting an annoying or obnoxious behavior, you could <u>praise</u> something that the child is doing appropriately to redirect the child to the task at hand.

> Example: (Child): (Looking out window instead of listening to the caregiver).
> (Adult): "Johnny, I like the way that you are sitting up in your seat!"

The adult/caregiver is able to get the child's attention and stop the annoying or obnoxious behavior without focusing on the child's negative behavior.

Redirection using Reflection

Redirection in <u>reflection</u> may be used when a child begins to tell <u>lengthy stories</u>. It is important to get the child to pay attention to the task at hand. Thus, when storytelling happens, the adult/caregiver could give a short reflection to the child and then redirect the child to the activity.

> Example: (Adult): "What does the word 'umbrella' mean?"
> (Child): "I once had an umbrella with a unicorn on it. It was really nice. I also read a book about unicorns. Do you know what it said? It said that you should never keep a unicorn in your back yard because it wants to be with its Mommy."
>
> (Adult): "Wow, you read a book about unicorns. Tell me what the word 'umbrella' means."

Redirection using Imitation

If a child begins to show an annoying or obnoxious behavior in play, the adult/caregiver could <u>imitate and model</u> the appropriate behavior to the child to redirect the child to playing appropriately.

> Example: (Child): (Pats Play-Doh on the table. Then, begins banging Play-Doh on the table.)

(Adult): (Begins patting Play-Doh on the table gently.) "I'm going to pat my Play-Doh on the table just like you, but I'm going to do it very gently and quiet like a mouse."

Redirection using Description

The caregiver may describe the child's appropriate behavior to redirect the child from engaging in inappropriate behavior.

Example: (Child): (Whining)
(Adult): "I can see that you have your paper and crayons on your desk and are ready to work!"

Redirection using Enthusiasm

Enthusiasm is an effective way to redirect a child to a task if the child is engaging in annoying or obnoxious behavior. If the caregiver makes the task seem really fun and interesting, the child will become interested in the task at hand.

Example: (Child): (Begins playing with shoelaces instead of paying attention to the book that the caregiver is reading.)

(Adult): (Flips through the book without letting the child see the pages.) "Wow, there are dinosaurs on the next page! Oh my, it looks like baby dinosaur is getting into trouble!

Redirection with Groups

Redirection can be used for annoying or obnoxious behavior in groups when some children are exhibiting the opposite, appropriate behavior. The adult/caregiver can bring attention to the children who are behaving well so that the children who are misbehaving will want to behave appropriately to get attention as well.

Example: (Child): (Doing squats in lunch line.)
(Adult): "Wow, look at you (child standing still). You are standing so still in this line, just like a soldier!" "I like the way that you (child standing still) are standing still too!" "Oh boy, you (child previously doing squats in lunch line) are doing a great job of standing still now too!"

Exercise

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REDIRECTION WITH FUN, INCOMPATIBLE COMMANDS

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Redirection can be used for annoying or obnoxious behavior with fun, incompatible commands. The adult/caregiver can give the child a fun command to do that is incompatible with the behavior that he or she is currently doing.

Scenario	Fun, Incompatible Command
1. Some children are putting crayons in their ears.	1. Who can draw a picture of a house? 2. Would anyone like to help me pass out snacks? 3. I want to see how many children are ready to go outside. If you are ready, please stand up. 4. Today when we were on the playground I saw a bug. I wonder if you could draw a bug? 5. How many blue crayons are on the table?
2. Some children are blowing bubbles in their milk at snack time.	1. 2. 3. 4. 5.
3. A child is crying because he misses his mommy.	1. 2. 3. 4. 5.
4. Two children are laughing and calling each other "stinky."	1. 2. 3. 4. 5.

WHEN-THEN

When-then statements are used to get children to comply. When a child continues with a disruptive behavior and ignores the adult's/caregiver's positive reminders, the child is given the responsibility for the behavior by being able to choose what will happen. In when-then statements, small privileges are held back until the child performs a specified behavior.

Example: (Child):   (whining) "I want some juice. Where's my juice?"

(Adult):	"When you ask in a big boy voice, then I will give you some juice."
(Child):	(regular voice tone) "Can I have some juice?"
(Adult):	"That's a nice way to ask. Sure, here's some juice."
(Child):	(bossy) "Give me those crayons!"
(Adult):	"When you say 'please,' then I will give you the crayons."
(Child):	"Pleeeease."
(Adult):	"Nice asking. I like to share with you when you say please."

Adults/caregivers have control over several privileges. Instead of just giving these privileges to the children without expecting any positive behavior in return, adults/caregivers can use these privileges as rewards for positive behaviors by using when-then statements.

Exercise

PRIVILEGES

Privileges I Control	When-Then Statement
1. Games	"When you pick up the crayons, then I will get the game down for you."
2.	
3.	
4.	
5.	
6.	

ACTIVE IGNORING AND SELECTIVE ATTENTION

Young children will work very hard for an adult's/caregiver's attention. Unfortunately, negative attention is often even more rewarding than positive attention because it is typically given in a very stimulating way. To reduce negative attention-seeking behavior, ignoring must be done in a very systematic fashion.

Active Ignoring is a technique in which the adult/caregiver explains to the other children that when a child behaves inappropriately, that child will be ignored. The children are taught that they must turn away from the child, remain silent, maintain a neutral facial expression, avoid eye contact, and make no movement in response to the child except to turn away. This concept should be role-played with the children so that they understand what to do. Also, good ignorers should be praised so that the children will want to ignore the disruptive child.

The **Ignoring Signal** (a "closed mouth" hand signal) should be taught to the other children so that the children know who is being ignored, and when to ignore that child.

Selective Attention such as praise or description, is given to children exhibiting appropriate behavior, while the adult/caregiver and the other children are ignoring the child behaving inappropriately.

As soon as the disruptive child begins to behave appropriately, even if it is just for a few seconds, return your attention and give an **enthusiastic labeled praise.**

Examples of behaviors to ignore:	whining, crying, playing with shoelaces, hands inside shirt, bossiness, complaining, pleading, acting younger than their age, arguing

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Higher Level Skills with Active Ignoring and Selective Attention

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1. **IGNORE** the inappropriate behavior of the disruptive child.

2. **SCAN** the room for children behaving appropriately.

3. **LABEL PRAISE** children for behaving appropriately.

4. **WATCH** the disruptive child out of the corner of your eye for the first instance of appropriate behavior.

5. **LABEL PRAISE** the disruptive child for behaving appropriately.

Example:	(Adult):	"Children, please put your art work away."
	(Mary):	(Continues drawing.)
	(Adult):	(Ignores child and scans the room for someone who is following instructions.) "Johnny already has his art work in the box. Thanks for being so fast, Johnny."
	(Mary):	(Looks up when Johnny is praised and quickly put away her art work.)
	(Adult):	"Why, Mary! I sure appreciate you getting your art work put away. Good listening!"

Managing Dangerous and Destructive Behavior

Giving Good Directions

When giving instructions to children who mind well, it is most appropriate to ask them nicely whether they would like to do something (e.g., "Could you be a big helper and pick up that trash that fell off the table?"); however, oppositional children often will interpret these nicely-stated instructions as meaning that the adult/caregiver is flexible about the command and that the limits can be tested. To increase the chances that the oppositional child will mind and follow instructions, commands should be:

Direct not Indirect

Use commands that make it clear that the child is expected to do what the adult/caregiver has requested. Commands such as "Let's clean up now" or "How about getting in line?" should be eliminated because the child may interpret them as meaning that (s)he has a choice in the matter when in fact there is none. If the oppositional child thinks that the adult/caregiver is merely suggesting that (s)he do something that (s)he doesn't want to do, compliance is unlikely. Direct commands should be used when it is important that the child do the required behavior.

Positively Stated

Try to tell the child what **TO DO**, rather than what **NOT TO DO**. Replace "Don't…" and "Stop…" commands with instructions requiring the child to do something incompatible with the problem behavior (e.g., Instead of saying, "Don't touch him with your foot," adults/caregivers should say "Please keep your foot to yourself.")

Single rather than Compound

Give commands one at a time rather than stringing several together (e.g., avoid commands like "Go put your coat on the rack and then choose a book."). Also, break large commands down into smaller parts (e.g., Instead of "Get ready for snack time," use a series of smaller commands such as "Put your books back on the shelf," "Please push in your chair," "Please line up.").

Specific not Vague

Tell the child specifically what is expected. Replace commands such as "Be good" or "Straighten up" with more specific instructions such as "Use your indoor voice" or "Keep your hands to yourself."

Given in a Neutral Tone of Voice

Because the oppositional child tests the limits, the adult/caregiver can easily get into a pattern of raising the voice to get the child's attention. Unfortunately, yelling is a trap. Once an adult/caregiver begins to use yelling as the signal that (s)he means business, the oppositional child realizes that they can get away with ignoring instructions given in a neutral tone of voice. All instructions should be given in a neutral but firm tone of voice, with no indication of pleading.

Polite and Respectful

Commands can be direct, clear, and firm without being disrespectful to the child. It helps to preface commands with "Please."

Given for Things the Child is Developmentally Capable of Doing

If the adult/caregiver is unsure whether a child can do something, the instructions should be given in an indirect fashion. Direct, firm commands should be reserved for things within the child's physical and cognitive capabilities.

Used Only When Really Necessary

Direct, firm commands should be reserved for times when it is important that the child obey. The adult/caregiver can provide choices or suggestions at other times. Hyperactive children typically need 5 times as many commands as calmer children, unnecessary commands should be eliminated through ignoring or physically prompting the child (e.g., physically lead them back to their seat without using an instruction).

Accompanied by a Rationale

Sometimes (not always) it is helpful and appropriate for the child to be given an explanation for why a request is being made. The rationale should either precede the command or be provided

after the child has obeyed. It should not come after the command and before compliance because many children will argue or ask questions to stall for time. Also, children can easily forget the original request if the rationale follows the instructions.

Incorporate Choices When Appropriate

It is helpful for children's development of autonomy and decision-making to be presented with a choice between doing two appropriate behaviors or activities. "Choice" commands should be very simple and issued at a level consistent with the child's cognitive level (e.g., "You can either color your pumpkin **or** play at the block table").

Broken Record

When a child does not listen right away, adults/caregivers can use a broken record, instead of nagging or yelling. The broken record is especially helpful for children who argue or try to talk adults/caregivers out of something. Repeat the direction or rule **using exactly the same words and the same calm tone of voice** and use a gesture to help the child understand (like pointing to the toys that need to be picked up). The broken record is only effective if you can keep a neutral facial expression and neutral tone of voice. Any deviations from the original words will lead children to argue and disobey because of the negative attention. A broken record statement should be repeated only three times. Five seconds of silence should elapse between each of the statements. If the child has not complied by then, it is best to either physically assist the child in following the instruction or provide a two-choices statement (e.g., "You have two choices. You can either put your coat on right now <u>or</u> we will stay inside.").

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EXAMPLE OF THE BROKEN RECORD

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Adult/caregiver:	"Please put your blocks away" (points to the socks).
Annie:	(ignores)
Adult/caregiver:	(continues pointing to blocks and silently waits five seconds) "Please put your blocks away."
Annie:	"I don't want to."
Adult/caregiver:	(continues pointing to blocks and silently waits five seconds) "Please put your blocks away."
Annie:	"Okay."
Adult/caregiver:	"Thanks for helping."

Two-Choices Statements

A two-choice statement provides children with responsibility for their behavior by allowing them to choose between demonstrating an appropriate behavior or accepting a logical consequence for continuing to demonstrate an inappropriate behavior. A two-choice statement can be said as "You have two choices. You can either (do the appropriate behavior) or (receive a

consequence)." It is helpful to use a visual signal with the two-choice statement. As you are saying, "You have two choices…" show the child the number two with your hand.

SOME TIPS FOR USING A TWO-CHOICES STATEMENT

✓ Never give empty threats. Adults/caregivers lose credibility with children if they threaten a consequence with which they cannot actually follow through (e.g., you have to sit in your seat for the rest of the day, you are never going to get to go outside).

✓ When possible, state choices positively (e.g., Instead of "You have two choices. If you don't stop putting paste on your friend's face, I'll take it from you," an adult/caregiver can say, "You have two choices. You can choose to keep the paste on the paper or I will put it away.").

✓ Avoid a hostile, confrontational tone of voice (e.g., "Stop touching that T.V. or you're out of here!"). It encourages the child to view the choices as a challenge. If you make it clear that you are going to calmly allow the child to take responsibility for the choice, they'll be more likely to choose the responsible alternative (e.g., "You have two choices. You can keep your hands to yourself or you'll have to leave the movie area.").

✓ With an angry child, walk away and give them a couple of minutes to consider a choice before demanding a response. Standing over a child can often force the child to choose the challenging option, as the physical threat does not allow them a "good out" (e.g., "You have two choices. You can come back in the room, or you'll have to go to your room. I'm going to walk over there and give you some time to think about your choice. It is up to you.").

✓ Take a hostile child aside so that the choice can be made without the influence of an audience.

EXERCISE
TWO-CHOICES STATEMENT

Misbehavior	Appropriate Behavior	Logical Consequence	Two-Choice Statement
1. Throwing Play-Doh	Keep the Play-Doh on the table.	Put it away.	You have two choices. You can keep the Play-Doh on the table or I will put it away.
2. Two children fighting over a doll.			
3. Two kids are playing aggressively with the			

swing.

4. Child is playing with a
    toy gun.

5.

6.

Time-Out – The Last Resort

Time-out should only be used as a last resort if other strategies have been unsuccessful at managing misbehavior. In fact, there are only three behaviors for which time-out would be an appropriate discipline choice: **serious defiance, hurting, and destruction of property.**

Time-out is most effective when a warning is given prior to the time-out. In most cases, the broken record technique should be used first. If this is unsuccessful, a two-choice statement can be given. For example, the adult/caregiver might say, "You have two choices. You can play gently with other children or go to time-out." The warning also could be in the form of a rule. The child could be told that we have a "no hurting" rule. If you hurt someone, even if by accident, you must go to timeout. Young children must be reminded of the rule often and should be praised if they obey the rule ("I'm so proud of you for not hurting this morning. Because you're being gentle, you don't have to go to time-out). As time-out is only effective when used sparingly, adults/caregivers should avoid using time-out more than two to three times per day for an individual child.

TIPS FOR USING TIME-OUT

- ✓ **Place an adult-sized chair** in the middle of an empty area. Avoid putting it against a wall as the child will be tempted to kick the wall. Avoid putting it near objects (e.g., books, toys, plants) as the child will be tempted to play with the objects.

- ✓ **Practice time-out in advance,** when the child is not in trouble. This may be done at the beginning of each day. This will teach the child the rules of time-out when (s)he is in a good mood and able to learn. This can be done with individual children or with a group.

- ✓ Use a timer and **set the time at approximately 3 minutes.** For some 3 and 4 year-olds, a 1 or 2 minute time-out is effective. You may want to begin with a very short time-out (about 20 or 30 seconds) to teach the child to sit appropriately. Then increase the amount of time each day. The duration of the time-out should be the shortest amount of time that is required for the desired behavior change. In fact, some time-outs may be as short as 40 seconds; however, most will be approximately 3 minutes. No time-out should be longer than 9 minutes.

✓ The adult/caregiver should **always be in control of the timer** as well as when the child can leave the time-out chair. Many children will ask to hold or play with the timer; however, this should be avoided.

✓ If the child refuses to go to time-out, **stay calm and quiet** and simply pick the child up and put him/her in the time-out chair.

✓ **A back-up is needed** for the following major disruptions in time-out: 1) leaving time-out, 2) standing on the time-out chair, 3) scooting or rocking the time-out chair, 4) screaming, 5) spitting, 6) vomiting, 7) swearing, and 8) urinating. If the back-ups are role-played with the children in advance, they are less likely to engage in major disruptions.

✓ If the child was **sent to time-out for serious defiance,** the time-out ends when the timer goes off AND the child agrees to comply with the original rule or direction. If the child has refused to comply after 9 minutes and appears calm, the adult/caregiver should attempt to physically guide the child to comply.

✓ After a time-out, the adult/caregiver should **provide a little special attention to decrease the child's anger** and increase future cooperation.

Time-Out Series

Some children may exhibit difficult behaviors (e.g., swearing, scooting the time-out chair, screaming) in time-out. If this occurs, give the child one warning (e.g., "You have two-choices. You can be quiet or go to the back-up area."). If the child persists, calmly take the child to the back-up area. Some children will continue to exhibit behaviors that cannot be tolerated in time-out. In these cases, give the child another warning involving one of two ultimate consequences. The two ultimate consequences should be _____ or _____.

Time-Out in the Classroom	⟹	Time-Out in an Acceptable Back-up Area	⟹	Ultimate Consequence
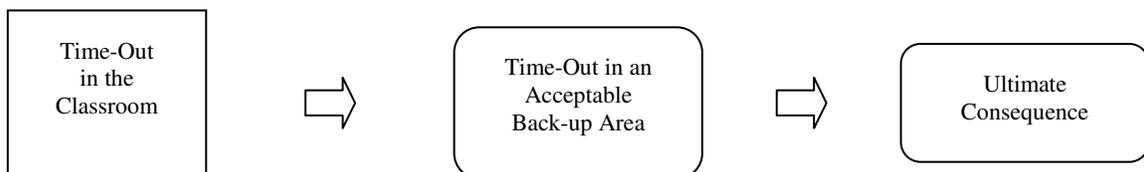
SOME TIPS FOR GETTING AN
AGGRESSIVE AND DEFIANT CHILD TO TIME-OUT

❖ Never pull a child by the arm.
❖ If the child has to be carried, carry the child with his/her back to the adult's chest.

❖ If there is any physical altercation with a child (e.g., the child has to be carried or escorted to time-out), write an incident report and discuss the time-out with the supervisor.

Unacceptable Back-Up Areas	Acceptable Back-Up Areas
• Bathroom • Closet • Any area which contains dangerous materials (e.g., kitchen) • Dark areas • Areas that cannot be observed or well-supervised • Areas that do not have proper ventilation • Near an exit door • Outside	• Child-proof • Well-lighted • Observable • Safe • Properly supervised by a person who has been trained in how to do a back-up time-out • Some options include: a director's office, hallway, empty room, another room, or the corner of a room

Understanding, Preventing, and Managing Child Misbehavior

Questions to Ask	Cues to Help
1. Why is this child misbehaving?	✓ To get attention ✓ To get something ✓ To get out of something ✓ To stimulate themselves
2. In hindsight, how could I have prevented this misbehavior?	**P**raise **R**eflection **I**mitation **D**escription **E**nthusiasm
3. What would be a positive way to handle the misbehavior?	✓ Redirection ✓ When-Then ✓ Active Ignoring ✓ Selective Attention ✓ Giving Good Directions ✓ Broken Record ✓ Two-Choice Statement
4. Is this a last resort situation where the child should go to time-out?	✓ Serious Defiance ✓ Hurting ✓ Destruction of Property

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Appendix E

CDI Homework record

WEEK 1 DATE:	Did you practice play therapy for five minutes?		Note any problems that came up:
	YES	**NO**	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Appendix F

ADI Homework record

DISIPLINE HOMEWORK SHEET

DATE:	Did you practice the skills? YES	NO	Time outs	How long?	Prompts?
Monday				1_____ 2_____ 3_____	
Tuesday				1_____ 2_____ 3_____	
Wednesday				1_____ 2_____ 3_____	
Thursday				1_____ 2_____ 3_____	
Friday				1_____ 2_____ 3_____	
Saturday				1_____ 2_____ 3_____	
Sunday				1_____ 2_____ 3_____	

Appendix G

Job satisfaction Survey

	Yes/No	
1. I look forward to going to work on Monday morning.	Y	N
2. I feel positive and up most of the time I am working.	Y	N
3. I have energy at the end of each work day to attend to the people I care about.	Y	N
4. I have energy at the end of each work day to engage in personal interests.	Y	N
5. I have the time and energy in my life to read books that interest me.	Y	N
6. Most interactions at work are positive.	Y	N
7. I have good friends at work.	Y	N
8. I feel valued and affirmed at work.	Y	N
9. I feel recognized and appreciated at work.	Y	N
10. Work is a real plus in my life.	Y	N
11. I'm engaged in meaningful work.	Y	N
12. I feel free to be who I am at work.	Y	N
13. I feel free to do things the way I like at work.	Y	N
14. My values fit with the organizational values.	Y	N
15. I am aligned with the organizational mission.	Y	N
16. I trust our leadership team.	Y	N
17. I respect the work of my peers.	Y	N
18. I have opportunities to learn what I want to learn.	Y	N
19. I feel involved in decisions that affect our organizational community.	Y	N
20. Creativity and innovation are supported.	Y	N
21. I feel informed about what's going on.	Y	N
22. I know what is expected of me at work.	Y	N
23. I have the materials and equipment that I need in order to do my work right.	Y	N
24. I have the opportunity to do what I do best every day at work.	Y	N
25. My manager cares about me as a person.	Y	N
26. I know someone at work who encourages my development.	Y	N
27. My opinions count.	Y	N
28. My coworkers are committed to doing quality work.	Y	N
29. My manager reviews my progress.	Y	N
30. I am fairly compensated.	Y	N

Give yourself two points for each statement you answered positively. Use the following scale to evaluate your current level of satisfaction with your job.

50-60 points: Extremely positive **40-48 points:** Positive
30-38 points: Average **20-28 points:** Below average
2-18 points: Poor