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What is This?
The Effects of Staff Training on the Types of Interactions Observed at Two Group Homes for Foster Care Children

Kimberly A. Crosland
Glen Dunlap
Wayne Sager
Bryon Neff
Catherine Wilcox
Alfredo Blanco
Tamela Giddings
University of South Florida

Objectives: An extensive literature base exists for behavioral parent training; however, few studies have focused on training direct care staff at group home and residential facilities for children. This study was conducted to determine whether a behavioral staff training program consisting of classroom training and in-home feedback would improve staff interactions with children at two group foster care homes. Method: Staff at both homes were trained, and direct observation measures were obtained on positive and negative interactions and lack of interactions. A multiple-baseline design across homes was used to assess staff interaction behavior. Results: Increases in both positive interactions and tool use were observed in the treatment phase, as were decreases in negative interactions for both group homes. Conclusions: The results suggest that training direct care staff, including social workers, to use behavioral strategies change patterns of interaction, resulting in a greater likelihood of improved relationships between staff and children.

Keywords: staff training; behavioral caregiver training; child welfare; Behavior Analysis Services Program

Over 500,000 youths are served in out-of-home care each year in the United States (Child Welfare League of America, 2004). Due to differences in state reporting procedures, the exact number of children residing in shelter and group home facilities is unknown; however, there are over 180,000 licensed residential or group home beds available across the United States, suggesting that a large portion of children are living in these types of facilities (Child Welfare League of America, 2004). According to several studies, youths residing in group home facilities may exhibit high levels of social, emotional, and behavioral needs (Burns et al., 2004; Landsverk, Garland, & Leslie, 2002; Litonwini, Taussig, Landsverk, & Garland, 1999). Burns et al. (2004) conducted a national study of the child welfare system and found that almost half of the youths in care aged 2–14 years had clinically significant emotional or behavioral problems. This study also found that 88% of children residing in group home or residential facilities had clinically significant behavioral and social problems.

Numerous studies have shown the effectiveness of behavioral parent training with both biological parents and foster parents (Barth et al., 2005; Hampson, Schulte, & Ricks, 1983; Lundahl, Nimer, & Parsons, 2006; Smagner & Sullivan, 2005). After an extensive literature review, only a handful of studies were found that have evaluated behavioral training for direct care staff working in group home settings with foster children (Braukmann & Wolf, 1987; Hurley, Ingram, Czyz, Juliano, & Wilson, 2006). The majority of direct care staff at shelters and group home facilities for foster children receive minimal to no training in behavior management strategies (Burns et al., 2004; Hicks-Collick, Burside-Eaton, & Peters, 2003). For example, a study conducted...
on the state child welfare system in California found that fewer than half of the agencies required training in behavioral management and that the training that was provided was often only 3 to 4 hr in length (Caring for Children in Child Welfare, 2004). While there appears to be a need for services aimed at training staff in how to manage youth behavior problems, it is unclear why so few staff are adequately trained. With regard to emergency shelter facilities, it has been suggested that perhaps the primary goal of these facilities is to provide for the basic needs of youths rather than other treatment services (Teare et al., 1994). However, children can reside in shelters and group homes for extended periods of time, suggesting that staff should be trained in ways to interact positively with children and in how to effectively manage problem behavior. Hurley et al. (2006) trained staff in a comprehensive program that included behavioral management components and skills building and found that direct care staff were able to implement the program. Shelter staff recorded their own interactions with youths, and several posttraining observations reported that staff were meeting the goal of an 8:1 ratio of positive to negative interactions. Baseline data for staff interactions were not collected during this study.

The purpose of the current study was to extend the current literature base on caregiver behavioral training by including as participants direct care staff from two group homes for foster care children. A behavioral training curriculum was designed to encourage staff to engage in positive interactions with children and use alternative proactive strategies for managing problem behavior. Two levels of analysis were conducted. The first employed all staff interactions in the home as the unit of analysis, while the second used the interactions of individual staff members as the unit of analysis. Both analyses were conducted within the context of a multiple-baseline design.

**METHOD**

**Participants and Settings**

Staff of two group home programs serving children in foster care were referred for training by the community-based care organization responsible for the oversight of the child welfare agency that administered the group home programs. Specifically, the community-based care organization requested that their staff members receive the Essential Tools for Positive Behavior Change training provided by the Behavior Analysis Services Program (BASP). Group home staff members included a clinical director, who supervised the entire house and supervised the therapists; lead staff, who supervised the direct care staff, arranged staff scheduling, managed client billing, and distributed funds and allowances to children; and the direct care staff, who supervised and interacted with all of the children. Because supervisors did not regularly interact with the children, observational data were obtained only with direct care staff. Staff members at both group homes were diverse in age, ranging from the early 20s to the late 50s, and had a range of experience in working with children in group settings. All staff were new to the group homes as they both opened approximately 3 months prior to the start of data collection.

For Group Home 1, a minimum of 20 min of direct observation data were collected during the baseline phase with 13 direct care staff members (3 men and 10 women). Of those 13 direct care staff, 5 (1 man and 4 women) completed the training. The other 8 direct care staff members for whom baseline observations were conducted did not complete the training because they were no longer employed at the home when training began. Five additional direct care staff members (all female) for whom it was not possible to obtain direct observation measures (e.g., they were hired immediately before the training occurred) also completed the training. Direct observation measures, a minimum of 20 min, were collected in the posttraining phase for all 10 direct care staff members who completed the training. High staff turnover at this group home, which appeared to be related to logistical personnel issues with staff not being paid in a timely manner, resulted in a limited number of observations of the same staff members within both phases of the study.

For Group Home 2, a minimum of 20 min of direct observation data were collected during the baseline phase with 9 direct care staff members (7 men and 2 women). Of those 9 direct care staff, 5 (4 men and 1 woman) completed the training. The other 4 direct care staff members for whom baseline observations were conducted did not complete the training because they were no longer employed at the home when training began. Direct observation measures, a minimum of 20 min, were collected in the posttraining phase for all 5 direct care staff members who completed the training.

Both of the group homes were located within a metropolitan area in the southeastern United States. Group Home 1 was a 12-bed facility for teenage girls (all girls were between the ages of 12–17 years), and Group Home 2 was a 6-bed facility for teenage boys (all between the ages of 12–17 years). All of the children in the homes were in foster care. Training sessions and pre–post test evaluations were conducted either in a classroom located at the community-based care organization’s headquarters or in one of the group homes. Trainings were conducted during school hours, and children were not present. All direct observations were conducted in the context of the two group homes.
Data for all participants were collected as a regular part of service provision within the BASP (see description below). Approval for use of existing data collected during general service provision for purposes of research and dissemination was obtained from the university’s Institutional Review Board (IRB).

**Baseline**

The baseline condition consisted of observations obtained prior to the implementation of BASP training. Staff training pertinent to this phase was limited to the standard training that direct care staff receive during employee orientation. Specifically, within the 1st week of employment, all direct care staff are trained in general policies and procedures, the Techniques for Effective Aggression Management (T.E.A.M.) training involving the use of safe physical interventions when necessary (Ward, Beane, Potts, & Pensel-Potts, 2003), and the point system that was in place at each group home. The T.E.A.M. training techniques were taught to staff to help ensure that safe physical interventions were used during crisis situations. During both the baseline and the posttraining phases, behavior analysts did not provide advice to staff or changes regarding the T.E.A.M. training. The point system in place at both facilities consisted of a five-level system in which each level defined the activities that the child could earn or lose on the basis of the child’s making good choices and being a positive role model for others. This was defined as the child following directions on the first request, completing chores, using manners, completing homework, using nice words, completing hygiene, keeping personal space clean, ignoring house conflicts, not instigating others, and helping staff. The five-level point system was in place throughout the entire study. No other training was provided during baseline regarding how to manage problem behavior and interact with the children.

**Training Program**

**Behavior Analysis Services Program.** All training was conducted by certified behavior analysts employed by the BASP. The BASP is contracted through the Department of Children and Families in the state of Florida to provide competency-based behavioral parent training and other behavioral services to caregivers and children in the child welfare system (Van Camp, Borrero, & Vollmer, 2003). The population in the child welfare system encompasses biological, foster, relative, and adoptive caregivers and children, as well as institutional staff and children. The BASP training was designed to help caregivers learn how to teach children appropriate behavior and replace problem behavior with more socially acceptable alternative behavior using proactive strategies. For additional information about the BASP, readers are referred to the article by Stoutimore, Williams, Neff, and Foster (in press).

**Training curriculum.** Training for staff members at both group homes consisted of 15 hr of classroom-based instruction on the Essential Tools for Positive Behavior Change curriculum. Staff members from both homes attended five 3-hr sessions over a 5-week period (one 3-hr session per week). All training was delivered by board-certified behavior analysts. Teaching methods included a combination of didactic instruction, group discussion, activities, practice, and role-play scenarios. During all classes, there was an emphasis on the demonstration of parenting skills that were taught through role plays in which a behavior analyst plays the role of the child while class participants demonstrate their ability to use a new tool.

The basic curriculum included training in the use of six “tools” to increase desirable child behaviors and decrease undesirable behaviors. The curriculum is based on basic behavior analytic principles and was developed primarily from the book *The Power of Positive Parenting* (Latham, 1990). Each group home received a copy of this text. Table 1 describes each tool and the behavioral procedure and rationale associated with that tool. In the curriculum, each of the tools is task analyzed with a list of critical behaviors and scored for accuracy. Staff members at both homes were taught the tools using these task analyses. The description of each individual task analysis is provided in Appendix A. For further details on the curriculum, please refer to Van Camp et al. (2003).

**TABLE 1: Description of Tools in Curriculum**

<table>
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<th>Behavioral Procedure and Rationale</th>
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<tr>
<td>Stay close</td>
<td>Noncontingent attention; used to make the caregiver’s approval and disapproval important to the child, thus establishing the caregiver’s attention as a reinforcer</td>
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<tr>
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<td>Positive reinforcement in the form of praise or access to desired items and activities; used to strengthen desirable behavior and weaken undesirable behaviors</td>
</tr>
<tr>
<td>Redirect, use reinforcement</td>
<td>Extinction of attention-maintained behavior and reinforcement for desired behavior; used to reduce minor, nonharmful problem behavior and increase appropriate behavior</td>
</tr>
<tr>
<td>Pivot</td>
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</tr>
<tr>
<td>Set expectations</td>
<td>Reinforcement for meeting expectations set by caregiver and child; used to strengthen desired behavior(s)</td>
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<tr>
<td>Use a contract</td>
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Observation and Data Collection Procedures

**In-home feedback.** At the end of each in-home observation period, the behavior analyst provided positive feedback in the form of praise to staff members on their use of positive interactions and tool steps. The behavior analyst also provided feedback on specific interactions that he or she observed in which staff members could improve their tool use or engage in positive interactions. Staff were also given time to ask specific questions related to the training or behavior of specific children in the home.

**Observation and Data Collection Procedures**

**Pre–post test assessment.** During the first and last weeks of class, each staff member participated in six role-play scenarios specific to the tools that were taught during class (i.e., stay close, use reinforcement, pivot with one child, pivot with two children, redirect and use reinforcement, and setting expectations). The only tool that was not tested in a role-play scenario was contracting, as this tool is a written form of setting expectations and is not particularly suited to a role-play scenario. Each of the role-play scenarios was scripted in that the description given to participants prior to the role play was the same and the behavior analysts’ behavior while they were acting as the child remained consistent during both the pre- and posttest. The goal of the behavior analyst acting as the child in the role plays was to allow the opportunity for the participant to complete each step of the particular tool that was being role played. The participant was asked to respond how he or she normally would in the given situation. The purpose of the role-play scenarios was to assess each participant’s acquisition of the tools taught in class.

Each tool has a checklist based on the task-analyzed steps described in Appendix A. During each role play (pre- and posttest), the behavior analyst scored whether the staff member correctly demonstrated the step or did not correctly demonstrate the step or whether the step was not applicable. A step could become inapplicable on the basis of the prior behavior of the staff member during the role play. For example, a step in the Redirect, Use Reinforcement skill was for the staff member to provide reinforcement (such as praise, items, privileges, etc.) following appropriate behavior. The next step was for that consequence to be delivered within 3 s of the occurrence of appropriate behavior. Therefore, if the staff member did not provide reinforcement, then the step for providing the reinforcement within 3 s became inapplicable. Each staff member’s percentage of steps performed accurately on any given skill was calculated by dividing the number of steps performed correctly by the total number of applicable steps, multiplied by 100%.

**In-home observations.** Behavior analysts and student interns from a social work master’s degree program served as observers during all of the in-home observation sessions. Prior to the study, all observers were trained in the operational definitions and observational procedures until they achieved high levels of interobserver agreement (minimum of 80% agreement). Multiple observations were conducted each week at both group homes, with each observation being 20 min in length. Approximately 60–100 min of data collection per week occurred at each home. Although observations were always conducted when children and direct care staff were in the home, the days and times of observation were not scheduled in advance. This practice prevented staff from preparing for the observations, and it allowed flexibility in the observers’ schedules. A number of variables (e.g., illness, vacations, and holidays) caused irregularities in the collection of observational data, and therefore there were several weeks during which no data were obtained (this is discussed in more detail in the Results section).

A 1-min interval-recording procedure was used to record staff–child interactions. The observational data sheets were divided into 20 1-min time periods in which observers recorded the occurrence or nonoccurrence of three types of interactions: positive interactions, negative interactions, and no interactions. Operational definitions of these variables were as follows. A positive interaction was defined as any accurate (100% of steps) use of a tool with a child, doing something for a child when the child’s presence is required (e.g., braiding hair), doing something for a child when the child requests it (e.g., getting the child a snack when the child says he or she is hungry or asks for a snack), interactions with a child that include a calm or pleasant tone of voice, offers to help, touching appropriately, “just” talking, smiling at a child, listening to a child, expressions of concern for a child, or playing a game with a child. A negative interaction was defined as the use of any of the 12 coercives (questioning, arguing, sarcasm, force, threats, criticism, despair, logic, telling on them to others, taking away privileges, items, allowances, one-upsmanship, and silent treatment) or any interaction that might cause harm to the child. (Please refer to Appendix B for a detailed description and an example of each coercive.) No interaction was scored if the caregiver did not engage in any interactions with children for the entire 1-min interval. On the basis of the definitions, both positive and negative interactions could occur and be scored during the same interval. Each minute started another interval for which the occurrence of both types of interaction could be scored again. For example, if a staff member was engaged in a positive interaction (i.e., playing a game) with a child during Minute 1 that continued into Minute 2, then the box for positive interactions on the data sheet would be checked for both intervals. All observations occurred between the hours of 2:00 p.m. to 10:00 p.m., as these were the hours when the majority of children and staff were present. Data collectors...
recorded the primary activity occurring at the start of the 20-min observation and noted, if necessary, the minute interval in which the activity changed and recorded new activities for each change that occurred. Data were collected across several different daily activities including leisure time, TV time, mealtime, and homework time. Table 2 lists the percentage of data collected during each specific activity during both baseline and posttraining for each group home. Observers chose one staff member at a time to observe. Then, after 20 min of observation of the first staff member, observers randomly chose another staff member for the next 20 min of data collection. This rotating process continued for the entire observation period. Observers typically attempted to collect a minimum of 20 min of data on each direct care staff person during every visit. For some visits, more than 20 min of data per staff person were collected if, for example, only 2 staff members were present. This happened most frequently at Group Home 2, where only two direct care staff members typically worked on each shift since fewer children resided at this location. All of the data collected from individual staff members each week were then combined across all intervals to calculate a weekly total for each group home. The weekly average was then calculated from this total for each dependent variable (e.g., to calculate the percentage of positive interaction for 1 week, the total number of 1-min intervals with positive interactions that week was divided by the total number of observation minutes per week).

Prior to the observations, the behavior analysts attempted to minimize interaction during data collection by instructing the direct care staff that they would only be observing and would be available at the end of the observation time to engage in discussion or any questions they might have. If a child approached during data collection, the behavior analyst would attempt to briefly answer the child’s question or tell the child he or she would talk to the child later (i.e., after the observation).

Interobserver Agreement

Interobserver agreement scores were obtained by having two observers independently collect data across 15% of sessions at Group Home 1 and 20% of sessions at Group Home 2, distributed across baseline and posttraining phases. Agreement was calculated by dividing the total number of intervals with agreement by the total number of intervals with agreement plus intervals with disagreements and multiplying by 100%. For Group Home 1, agreement was 89% (range = 70%-100%) for positive interactions, 92% (range = 75%-100%) for negative interactions, and 89% (range = 70%-100%) for no interactions. For Group Home 2, agreement was 91% (range = 65%-100%) for positive interactions, 96% (range = 75%-100%) for negative interactions, and 90% (range = 60%-100%) for no interactions.

Experimental Design and Units of Analysis

A multiple baseline across group homes was used to assess the effects of training on multiple types of staff–child interactions. Baseline data were collected simultaneously in the two group homes. Training was introduced to Group Home 1 after 24 weeks of baseline, while baseline continued in Group Home 2. Then, following changes in the dependent variables in Group Home 1, training was introduced to the staff in Group Home 2 at Week 35. Data continued to be collected through Week 48 at both group homes.

Analysis of the data was conducted in two ways. The first employed the behavior (staff interactions) of all staff present in the group home during a particular observation session as the unit of analysis. This was done in order to capture the overall interactional culture of the home, and because the actual staff who were present at any one time fluctuated a great deal, there was little stability or predictability of staff presence. In addition, however, we sought to determine whether changes could be observed in the behavior of individual staff. Thus, the second analysis was conducted using the data of all of the individual staff members who were present often enough in both pre- and posttraining phases to allow repeated-measures examinations of their interactions within the context of the multiple-baseline protocol.

RESULTS

Pre–Post Test Assessment

Scores were first calculated for each individual staff member’s responses for each tool by dividing the number of steps performed correctly by the total number of applicable steps, multiplied by 100%. The average score across all staff members who completed training

TABLE 2: Percentage of Sessions Conducted During Each Activity Type

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Group Home 1 Baseline</th>
<th>Group Home 1 Posttraining</th>
<th>Group Home 2 Baseline</th>
<th>Group Home 2 Posttraining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leisure</td>
<td>88</td>
<td>79</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td>TV</td>
<td>4</td>
<td>9</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>Meal</td>
<td>8</td>
<td>12</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Homework</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

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(10 staff for Group Home 1 and 5 staff for Group Home 2) for each group home and for each tool was then calculated. Figure 1 represents the six individual role-play scenarios’ pre- and posttest scores for both group homes. Group Home 1’s total pretest average across tools was 34.4% and improved to an average of 90% on the posttest. Group Home 2’s total pretest average across tools was 34% and improved to an average of 78.6% on the posttest.

Observational Data on Staff Interactions

The total length of the study for both group homes was 48 weeks. For Group Home 1, a total of 139 20-min sessions were conducted during 36 weeks; for Group Home 2, a total of 116 20-min sessions were conducted during 40 weeks. There were 12 weeks for Group Home 1 (8 in baseline and 4 in the posttraining phase) and 8 weeks for Group Home 2 (8 in baseline and 1 in the posttraining phase) in which data were not collected due to circumstances unrelated to the study (illness, holidays, etc.). The average weekly minutes of data collected at Group Home 1 was 73 min; for Group Home 2, it was 68 min.

Figure 2 displays positive and negative interactions for Group Home 1 (top) and Group Home 2 (bottom). These data represent the average of staff members who were present during observational sessions, thereby making the behavior of the staff in the home the unit of analysis. During the baseline phase, staff members at Group Home 1 engaged in an average of 15.4% positive interactions and 17.3% negative interactions during the observed intervals. Positive interactions increased significantly to an average of 75% of the intervals during the posttraining phase, while negative interactions decreased to 1.8% of intervals in the posttraining phase. Similar results were found for staff at Group Home 2, with the exception of baseline rates for positive interactions at slightly higher rates. Baseline averages were 29.2% and 10.1% of intervals for positive and negative interactions, respectively.
Posttraining averages for staff at Group Home 2 were 63.7% of intervals for positive interactions and 3.4% of intervals for negative interactions. Negative interactions were quite variable for both group homes in the baseline phase and showed a declining trend prior to the posttraining phase; therefore, it is difficult to make conclusions even though the overall average decreased. Negative interactions did continue to remain low in the posttraining phase, and a decrease in variability was observed. Positive interactions were also variable, specifically at Group Home 2, but increased substantially with less variability at both group homes during the posttraining phase.

Figure 3 represents the intervals in which no interaction was scored for both Group Home 1 (top) and Group Home 2 (bottom).

Individual Staff Data

It is important to appreciate that the data presented in Figures 1-3 are averages of observations of multiple staff members per session. The presence of individual staff members varied considerably across sessions due to the irregularity of the observations, fluctuations in staff schedules, and staff turnover. In an effort to determine whether similar trends in staff interactions would be seen for individual staff members, the data were examined on the basis of percentage of intervals for individual staff. To identify the presence or absence of trends, a criterion of at least three 20-min observations conducted during both the baseline and the posttraining conditions was established. A total of 4 staff members met this criteria, 1 staff member from Group Home 1 and 3 staff members from Group Home 2. Figure 4 contains a graph of interactions...
for each staff member (four panels total) that displays all 20-min observation sessions that were conducted during both baseline and treatment phases. Similar results were found in that all 4 individuals showed an increase in positive interactions and a decrease in no interactions when averaged across phases. There was only one session in which an increase in positive interactions was observed for Peter, and an increase in positive interactions just prior to training was observed for Alex. All individuals showed low levels of negative interaction throughout both phases, although greater variability was observed in the baseline phase for Kate.

DISCUSSION AND APPLICATIONS TO PRACTICE

Direct care staff members learned the strategies (i.e., tools) taught during the class as evidenced by their pre–post test role-play data. The direct observation part of the study attempted to evaluate the entire home environment prior to and after training. The Essential Tools for Positive Behavior Change curriculum did appear to change how staff at both group homes interacted with the children. Increases in positive interactions were observed at both homes. Negative interactions overall were low and on decreasing trends during baseline; therefore, the effect of the training is not as clear, but these interactions did remain low with less variability in the posttraining phase. It was encouraging to see that negative interactions did not occur at high rates at baseline. During the baseline phase, staff were most often observed not interacting with the children. Often, staff were talking with coworkers, completing paperwork, and doing chores (i.e., cooking or cleaning) without enlisting or encouraging help from the children. The latter situation in particular would be an ideal time for staff to interact positively with the children while teaching necessary life skills. During the posttraining phase, both group homes’ lack of interaction decreased, while positive interactions increased. Anecdotal observations found that staff members were engaging children in more life skills activities, such as preparing meals, and in other activities, such as board games. While there is a limited amount of individual staff data across both phases of the study, these data did appear to support the group data in that similar training effects were observed.

The current study found results similar to those obtained by Hurley et al. (2006) in that staff demonstrated increases in positive interactions. The primary focus of the Hurley et al. study was a pre–post comparison design that examined youth incident reports (e.g., runaway, violence, and use of restraints) while staff collected self-report data on their own interactions with children. The current study extends the literature base by collecting direct observation measures on staff interactions and by utilizing a more rigorous research design for demonstrating experimental control (e.g., multiple baseline design).

There were several limitations to the current study. Data were not collected on specific child behaviors; therefore, it is not known whether child problem behavior decreased as a result of the change in staff interactions. It is also not known whether children developed better relationships with staff members. Hurley et al. (2006) evaluated incident reports before and after behavioral staff training at a shelter for foster care children and found an overall 30% decrease in total incidents of violence, runaways, and other inappropriate behaviors. For the current study, an attempt was made to review incident reports at both group homes. After reviewing approximately 2 months of incident reports and talking with staff members, it appeared that the reliability of these reports was questionable. For example, some staff would record a runaway incident whenever a child left the home, while others only recorded it if the child was gone for a particular period of time (i.e., 1 hr). It would be advantageous for future researchers to collect direct observation data on both child and staff behavior in addition to permanent product measures. Direct observation data might show a decrease in specific problem behavior and, perhaps, the relation to staff behavior. For example, it could be determined that a decrease in a child’s swearing occurs as a result of the staff member ignoring the swearing behavior of the child and only providing positive attention when the child talks nicely. This could also be assessed for increases in appropriate behavior, such as compliance with staff demands.

This study involved both in-classroom training and in-home feedback. It is not clear whether the combination of these produced the changes in staff interactions or whether one of these alone would have resulted in similar change. There did appear to be an immediate effect of the classroom training in that positive interactions improved and no interactions declined during the first observation after training prior to in-home feedback; however, it is not known whether this effect would have diminished without the in-home feedback component.

The definitions for what constitutes a positive or negative interaction were difficult to develop, and for this study they were based solely on topography. This can cause discrepancies by assuming that a staff response is a component of a negative or positive interaction. For
example, if a child hits another child and the staff member
smiles and laughs, this by definition would be scored as a
positive interaction. Sarcasm could also at times be con-
sidered an enjoyable way of interacting, but since it is by
definition a coercive, it would be scored as a negative
interaction. These types of examples were rarely reported
by the data collectors, and the data collection remained
consistent with regard to the definitions in place across
both baseline and posttraining phases. Future research
may want to record child reaction to staff behavior as
another means for defining types of interactions.

Another concern is the lack of research on the
appropriate or ideal levels of each type of interaction
from caregivers. It has been suggested that caregivers
should strive for an 8:1 ratio of positive to negative
interactions; however, there is no specific research to
support this ratio (Dowd & Tierney, 1992; Hurley
et al., 2006; Latham, 1990). It might be assumed that
teenagers require fewer caregiver interactions since
they are, in general, more independent. Teenagers
within foster care, however, who have been exposed to
traumatic events, may be less likely to develop posi-
tive relationships with caregivers. It might be advanta-
geous to increase the amount of positive interactions
during relationship building and develop a plan for
fading the amount of interactions while concurrently
teaching independent skills. Future researchers could
observe children and well-trained caregivers in other
settings (i.e., biological parent’s home or foster
parent’s home) to determine what might be an ideal
level of each of the different interactions in relation to
child behavior.

To conclude, the current study demonstrated that behav-
ioral staff training—more specifically, teaching the tools
for positive behavior change—resulted in increases in the
positive interactions of direct care staff members at two
group homes for foster care children. These findings high-
light the importance of training direct care staff in ways to
interact positively with children and in how to effectively
manage problem behavior.

APPENDIX A
List of Steps for Each Parenting Skill—15-Hr Course

Tool 1: Stay Close
1. Get close to the child within 15 s of the stay-close behavior (move
toward child and be within arm’s reach, etc.).
2. Touch appropriately (pat, hug, rub, etc.).
3. Match facial expressions (appropriately reflect the emotion of
the situation).
4. Use appropriate tone of voice (voice matches situation; a neu-
tral monotone is not good enough).
5. Relax your body language within 15 s of the stay-close behav-
or (relaxed, arms open, attentive, looking at child, etc.).
6. Ask open-ended positive questions (what? how? could you?).
7. Listen while the child is speaking. Talk less than the child (do
not problem solve unless the child asks for help. Do not inter-
rupt or abruptly change the topic).
8. Use empathy statements (act like a mirror and reflect the child’s
feelings, express understanding, caring, etc.).
9. Avoid reacting to junk behavior (minor, nonharmful behavior).
10. Stay cool throughout the process (no coercives).

Tool 2: Use Reinforcement
1. Tell the child what behavior you liked (if this is appropriate).
2. Provide a positive consequence for the behavior that matches
the value of the behavior. (Circle those provided):
   - Social interaction
   - Verbal praise
   - Appropriate touch (hug, pat, kiss, high five, etc.)
   - Tangible item
   - Privilege
   - Break from task
3. Provide the positive consequence within 3 s of recognizing the
appropriate behavior (if possible).
4. Use sincere and appropriate facial expression, tone of voice,
and body language.
5. Avoid reacting to junk.
6. Avoid coercion and punishment.

Tool 3: Pivot
1. Say nothing about the junk behavior (e.g., don’t say “Stop that
now!” or “Quit doing that!”).
2. Do nothing to react to the junk behavior (e.g., don’t roll your
eyes, stomp out of room, cross your arms, stare, etc.).
3. Actively attend to another child, person, or activity (e.g., read
a book or praise another child for behaving appropriately).
4. Once the child who displayed junk behavior behaves appropri-
ately, provide reinforcement for the appropriate behavior (social
attention, praise, touch, item, privilege, break from task) within
10 s of recognizing the appropriate behavior of this child.
5. Stay cool. No coercives.

Tool 4: Set Expectations
Part I: Set the Expectations
1. Set the stage: time (away from the behavior).
2. Set the stage: place (uninterrupted).
3. Set positive tone.
4. State the expectation clearly and specifically (when, where,
what, and how).
5. Briefly reflect the child’s feelings (empathy), if necessary
(e.g., “You sound upset. . .”).
6. Briefly explain the benefits of this expectation only if the
child asks.
7. Ask the child to restate the expected behavior (use the broken
record method if needed).
8. Acknowledge and praise the child’s restatement of the expec-
tation (continuing to ignore any junk behavior).

Part II: Set the Consequences
1. State clearly the consequences for meeting and not meeting
the expectation.
2. Negotiate as necessary.
3. Ask the child to restate the behavior and the consequences.
4. Acknowledge and praise the child’s restatement.
5. Ignore the junk behavior of the child, if necessary.
6. Stay cool throughout the process (no coercives).

(continued)
APPENDIX A (continued)

Tool 5: Use a Contract
Part I: Make the Contract
1. Daily expectations (behaviors) are clearly and positively stated.
2. Weekly expectations are clearly and positively stated.
3. Expectations are reasonable for current performance.
4. Immediate consequences for meeting/not meeting are stated in terms of earn/not earn.
5. Delayed consequences for meeting/not meeting are stated in terms of earn/not earn.
6. Consequences match the value of the behavior.
7. Consequences are review times stated for daily and weekly review.
8. Stay cool and use no coercives.

Part II: Review the Contract
1. Discuss contract positively.
2. Notice expectations met and use lots of praise.
3. If expectation is met, deliver the immediate or delayed positive consequence (e.g., sticker, watch a TV show).
4. If expectation is not met, use one simple empathy statement and review the contract by asking child to state the expectation and the consequences.
5. Pivot to the planned discussion when junk behavior happens.
6. Stay cool throughout the process (no coercives).

Tool 6: Redirect; Use Reinforcement
1. Get within arm’s reach of the child (before saying anything).
2. Make sure the child stops the inappropriate behavior (use gentle physical guidance if necessary).
3. Calmly say something like, “Hey [child’s name], I want you to [state the positive alternative behavior].”
4. If the child does not begin to do the suggested activity within 3 s, model or gently guide the child to do the activity.
5. Use reinforcement when the child does the appropriate behavior (praise, touch).
6. Reinforce the behavior within 3 s after the appropriate behavior begins (stopping serious behavior may be the appropriate behavior).
7. Say nothing and do nothing about junk behavior throughout the process.
8. Stay cool and use no coercives.

APPENDIX B
Description of Coercives

Note: There may be disagreement concerning the application of the term coercives to all of the parenting behaviors listed below. The term is used here because it was the label adopted by the Behavior Analysis Services Program training curriculum, which was derived from the parenting tools delineated by Latham (1990).

1. Questioning: Asking questions when the caregiver does not really expect an honest answer and won’t accept the likely answer
   Example: The child has left his or her dirty clothes on the floor of the bathroom. You walk by and notice this, find the child, and say, “Where do your dirty clothes go? Why have you left them on the floor of the bathroom?”

2. Arguing: Attempting to force the child to agree and responding to any objection by the child
   Example: Both children have the chore of washing and drying dishes in the house. After dinner, you notice that only one child is working in the kitchen. You find the other child and tell him or her to go help with the dishes. The child says it is not his or her turn. You say the child is supposed to help every night. The child says he or she does not want to. You repeat that he or she needs to. And the back-and-forth talk continues.

3. Sarcasm/teasing: Making fun
   Example: Your 15-year-old comes to dinner 20 min late, and you say, “Thank you for gracing us with your company; we are so honored.”

4. Force (physical or verbal): Causing pain or creating fear
   Example: A child is running through the grocery store pretending to shoot people. You have asked the child to stop several times and finally grab the child by the arm, jerk the child with all your might, and drag him or her along next to you.

5. Taking away privileges, items, or allowance: Removing a desired or preferred activity, toy, or money after a child has misbehaved in order to make the child want to behave better in the future.
   Example: Your child starts fighting with his sister while watching TV. You turn off the TV and tell them that they have both lost TV privileges for the rest of the day.

6. One-upsman ship: Trying to give your child something to think about or show the child how good his or her life is by telling stories about how difficult your life has been or what would have happened to you if you had misbehaved.
   Example: You tell your child that when you didn’t listen to your father, he made you sit in the corner for an hour and sometimes you would get paddled.

7. Threats: A warning by caregivers that they will punish
   Example: Your teenager has come home late for the third weekend in a row, and you say, “If you are late one more time you will be grounded for the rest of the year.”

8. Criticism: Putting the child down
   Example: Your child has mowed the lawn, and you say, “Next time try to make the rows straighter so it will look nicer.”

9. Silent treatment: Obviously ignoring the child in order to punish the child. Ignoring past the point of the troubling behavior’s occurrence and the child’s behaving more appropriately
   Example: Your child decides not to complete her homework, so you decide that you will not speak to her until her homework is finished, which ends up never getting completed that evening.

10. Telling on them to others: Talking to others regarding the behavior of the child. If the child knows you have told others, the relationship with those others and you will be damaged; the child will be likely to get even with all involved.
    Example: Your child hit his brother. As soon as his father arrives home from work, you tell him how bad his son has been and exactly what he did while the child is in the room.

11. Despair/pleading/hopelessness: Saying or doing things to make the child change because he or she feels sorry for you or guilty for what he or she has done to you
    Example: Your child curses at you when you ask him or her to do something. You say, “I don’t know what to do with you. I take you in, give you more than you ever had before, and this is how you treat me. I guess there is nothing I can do to help you behave better.”

12. Logic: Explaining with more than one or two brief statements why a behavior is good or bad for the child. The explanation is especially likely to function as coercion if it is a frequent conversation between you and the child

(continued)
APPENDIX B (continued)

Example: Your child has not been going to classes. You begin to discuss this with the child as soon as he or she comes home. You begin by explaining the importance of an education for getting a good job. You explain that you want the child to succeed in life and that is why you push him or her to do well in school. You also explain that skipping classes is a breach of trust and that you cannot trust the child. This is the same conversation that you had with the child earlier this week.

REFERENCES


