

Evaluation of a Therapeutic Camp: Exploration of Personality Variables Predictive of Outcome

By

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PREVIEW

A Doctoral Project Submitted in Partial Fulfillment of  
the Requirements for the Degree of Doctor of Psychology  
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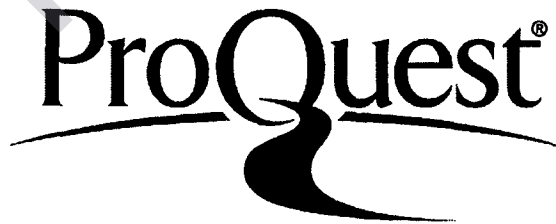
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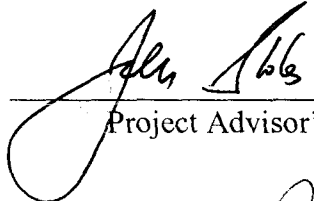
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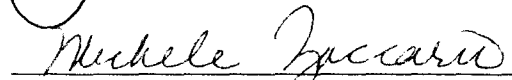
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## **ABSTRACT**

This study attempted to evaluate a community based therapeutic respite care summer camp program. By examining the relationships between participation in the respite care summer camp program with parental stress, behavior change and positive growth of children, this study can provide useful information in the assessment and treatment of children with a serious emotional disturbance (SED).

To assess the relationships between participation in the camp with parental stress, behavior change and positive growth, information on children, ages 5 to 16 years, was gathered from the caregivers of the children enrolled in the Family Services of Westchester (FSW) respite summer camp program as well as the staff of the camp. Findings indicated that there were significant relationships identified between participation in the FSW respite summer camp program with certain areas of parental stress, certain aspects of behavioral change and positive growth of children. Additionally, utilizing the reliable change indices it was identified that children reported by staff to demonstrate clinically significant issues within the Autism domain of the Devereaux Scale of Mental Disorders (DSMD) exhibited the most positive treatment response while children reported to demonstrate clinically significant issues within the Acute Problems domain of the DSMD exhibited the poorest treatment response. Limitations and directions for future research were discussed, as was the relevance of the current findings for the field of School-Clinical Child Psychology.

## CHAPTER 1

The normative trajectory for a child diagnosed with a serious emotional disturbance (SED) is a potentially perilous one (Zigmond, 2006). Their difficult or misunderstood behaviors often set the stage for a life filled with negative interactions with family, peers, teachers as well as society. Children diagnosed with an SED have disproportionately higher rates of dropout and academic failure, and they are more likely to be arrested, poor, unemployed, involved with illicit drugs and become teen parents (Kauffman, 1999). Furthermore, children with a serious emotional disturbance are under-identified and when they are identified it is further along in their life than any other subset of children with disabilities. This complicates and attenuates interventions that emphasize early identification, prevention and treatment efforts for this population (Nelson, Jordan, & Rodrigues-Walling, 2002).

Along with the poor outcomes for children diagnosed with an SED, there is a lack of appropriate services for this population (Walrath, Nickerson, Crowel & Leaf 1998). Schools and professional agencies within the communities often offer differing definitions of what constitutes a diagnosis of serious emotional disturbance. The lack of uniformity among school definition and classifications of SED, which stem from IDEA (Individuals with Disabilities Act), and psychiatric classifications of SED, which stem from DSM-IV can lead to problems and confusion in subsequent identification, allocation of services and treatment (Merrell & Walker, 2004). Additionally, many of the services for this population are restrictive (i.e. residential placements, acute-care hospitalizations), do not adequately treat behaviors or emotional needs, and fail to properly prepare these children to function successfully upon return to their home communities (Anderson & Mohr, 2003).

The risk factors for an SED child are broad in scope as well as impact. Risk factors associated with emotional disturbance permeate to the core of individual and family functioning.

Bradley, Henderson and Monfore (2004) found children with an SED to have the worst social and academic outcomes of any school population with a disability. The risk associated with children having a SED is also a developmental one as their complex emotional and behavioral needs make their transition to adulthood a difficult and potentially perilous one (Zigmond, 2006).

One major risk factor associated with children with an SED is the significant stress many caregivers of these children experience on a given day. Caregivers of children with an emotional disturbance have been found to experience more stress than caregivers of children who are not experiencing comparable levels of psychopathology (Morgan, Robinson & Aldridge, 2002). Literature has shown that caregiver stress has a debilitating impact on one's ability to function productively and parent effectively. Furthermore, it is associated with a host of other risk factors that can further jeopardize the functionality of the family system from a health and safety standpoint (Williford, Calkins, & Keane, 2007).

These risk factors underscore the importance of identification, support and treatment for children with an SED and their families. Due to the wide range of behaviors that manifests within children with an SED, it is essential to investigate differing types of SED behavior as well as symptom severity, treatment outcome and their subsequent relation to parenting stress. Internalizing behaviors, externalizing behaviors and callous/unemotional traits are three distinct categories of SED behavior that this review will examine.

Internalizing disorders are problems that appear to be related to issues occurring within a person, where they act out upon themselves rather than the environment. Externalizing disorders are characterized by patterns of behaviors directed outward, toward one's environment and potentially, towards peers. Some externalizing behaviors include rule-breaking, disobedience, aggression, violence, delinquency, temper tantrums, and over-activity. Additionally, there is a growing body of literature that speaks to a separate sub-group of externalizing youth, usually classified among Conduct Disorder and Oppositional Defiant Disorder children, whose collection of callous/unemotional traits require a separate classification. Research has shown for the

aforementioned categories of behavior that symptom severity of these behaviors is regularly associated with treatment outcome (Liber et al., 2010; Fergusson, Horwood & Ritter, 2005, & Frick, Cornell, Barry, Bodin & Dane, 2003).

Regarding treatments for the varying types of SED behavior, individual institutions protocols seem to slightly differ. More specifically, treatment for internalizing behaviors often include a protocol consisting of some or all of the following elements: psycho-education, exposure, cognitive restructuring, social skills training, social-problem solving, parent training and applied relaxation (Rodebaugh, Holaway, & Heimberg, 2004). Whereas many of the externalizing behavior treatment protocols for SED children consist of social skills training, anger management, parent-training and parent-child enrichment techniques (Webster-Stratton, Reid & Hammond, 2001). Treatments for children with antisocial, callous/unemotional traits are less researched but the available literature points to similar protocols as those utilized in treating externalizing behaviors. More specifically, those treatments that combine social problem-solving skills, social skills training and parent training have been found to show some promising results in treating antisocial callous/unemotional traits in children (Kazdin, Siegal and Bass, 1992).

A common thread tying the treatment protocols together for these varying types of SED behaviors is the inclusion of the social skills training and the parent training component. Research has demonstrated that social skills are a critical part of successful adjustment for a child and also play a key role in family functioning and more specifically, parent-child interactions and parental stress (Briggs-Gowan, Carter, Skuban & Horwitz, 2001, Deater-Deckard, 2000 & Mendez, Fantuzzo, & Cicchetti 2002). Children demonstrating internalizing and externalizing behaviors may have their ability to socialize successfully compromised and have been found to have caretakers who experience higher levels of parental stress and strain (Wiliford, Calkins & Keane, 2007; Tan & Rey, 2005). Therefore the importance of prosocial behavior and adequate social skills should not be underestimated when examining SED children and their family treatment needs.

Parent-training or parent-child interaction training is another treatment component that appears to be included in the majority of treatment protocols for children with an SED. The interrelatedness of parent-child interactions and subsequent parental stress and child behavior appears to hold true across all aspects of SED behaviors (Krain & Kendall, 2000; Ang, 2008 & Kazdin, Mazurick and Bass, 1993). Research has demonstrated the adverse impact parental stress has upon parental functioning. Parental stress leads to more negative parenting techniques. In turn, negative parenting behavior and strained family functioning can negatively impact the behavior and emotional well being of the children living in these homes (Renk, Roddenberry, Oliveros and Sieger, 2007; & Ritchie & Holden, 1998).

Contributing to compromised parental patterns and strained family functioning within the child with an SED environment is the fact that many of these families are poverty stricken and live in low-income communities where violence and antisocial behavior patterns are prevalent (Wagner et al. 2005). Hence the broad range of severe behaviors, the need for social skills and parent-training, the complex treatment needs and numerous risk factors associated with children having an SED, all point to a need for an array of services for this population.

The benefit of receiving social support for these caregivers have been well documented and has been shown to reduce stress and have a positive effect on parenting and the familial environment the child is raised in (Ceballo & Mcloyd, 2002). In families, it has been found that the presence or perception of social support was predictive of more positive outcomes for those family members where-as a perceived lack of support was associated with less positive outcomes (Demeray & Malecki, 2002; Guterman et al., 2009; Stice, Ragan, & Randall, 2009). Social and instrumental support can come in a number of different ways, whether it is from a family member, a peer, school, community organization or local civil service organizations.

Community based services in the form of “systems of care” have been documented in the literature as an effective means to help attenuate the negative impact of stressors upon families with special needs children (Eber et al., 2002). Systems of care offer families in need a

coordinated array of services to meet their family's unique needs. Some of the services that are potentially available to these families include: intensive case management, therapy, specialized school placements, family preservation, parental support, respite care and other services designed to keep children and families in their home communities and out of hospitals and residential placements (Eber et al., 2002). Wraparound services are the individualized service plans that have been formed out of family and service provider team cooperation. Wraparound services are useful because they are family and needs driven (Stambaugh et al., 2007).

Among families with special needs, particularly those with children with an SED, there is a shortage of appropriate respite/therapeutic recreational activities (Cowen & Reed, 2002, Hazell et al., (2002). Not only do these families feel stressed and over burdened by their responsibilities as a parent of a special needs child but their children, due to their conditions, are not afforded the same socialization opportunities as "normal" children (Marcenko, Keller, & Delaney, 2001). Additionally, the stress and strain of having to care for these children without appropriate supports compromises parenting and overall family functioning (Mullins et al., 2002). Furthermore, left to their own devices, youth who have demonstrated antisocial behavior or those who are on the periphery of social acceptance will be ultimately drawn to select peers similar to themselves, which only reinforces antisocial behavior norms and negative patterns of functioning (Mahoney, Stattin, & Lord, 2004).

Structured therapeutic recreational services are invaluable to children with an SED and their families. Other non-traditional recreational/outdoor therapies such as wilderness therapy and adventure-based therapy have shown promising results in working with this population. Respite care is a service that can also potentially provide therapeutic support and relief to children with an SED and their families. Respite care encompasses similar tenets to wilderness and adventure-based therapies and can provide a variety of flexible services, ranging from a short period of separation between the child with an SED and family to a therapeutic recreational program where

special needs children have the opportunity to socialize and learn coping and adaptive skills in an environment catered to meet their individual needs (Bruns & Burchard, 2000).

However within the literature there is only modest research on how children with an SED will respond to a therapeutic recreational/respite program. More specifically, there is a lack of common knowledge about the types of behaviors and symptoms that respond well to this type of treatment. There is also a dearth of literature on how a therapeutic recreational/respite program may ameliorate certain aspects of parenting stress. Additionally, there is scarcity of literature on how therapeutic recreational programs for children with an SED can help to identify child traits that minimize the potential benefit of this type of program.

It is for the aforementioned reasons that this current study may demonstrate valuable clinical utility. This current study will evaluate a respite program, specifically a therapeutic summer day-camp for children with an SED. The program is the respite program from the Family Services of Westchester (FSW). It is a nationally recognized respite program that has been featured at conferences across the United States. Unlike many respite programs, it specializes in therapeutic recreational programs. The philosophy guiding the FSW respite program is that respite care is conceptualized as more than providing a break and rest for the caregivers of the children in their program. It employs a strength-based, proactive model of behavior change that is based on the Positive Behavior Intervention and Supports model (PBIS). PBIS is an approach to behavior change that is utilized in many schools and community based programs working with children. PBIS focuses on individualized and proactive behavior change. PBIS does not employ punitive methods as a means to intervene with behavior (Eber & Palmer, 2002).

Specifically this study reviewed if participation in this therapeutic recreational/respite summer camp program was associated with changes in caregiver stress and behavior changes in campers over the course of the summer. Additionally, the study examined what types of behaviors and traits of children with an SED responded well to this type of intervention. Lastly, were changes in socialization skills and goal attainment within this type of therapeutic



recreational/respice program related to changes in caregiver stress and changes in camper behavior?

PREVIEW

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **Serious Emotional Disturbance**

According to the Center for Mental Health Services (1993), serious emotional disturbance is a DSM-defined psychiatric disorder resulting in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. This definition differs from the definition of emotional disturbance as put forth by IDEA (2006) concerning special education policy and services. IDEA defines emotional disturbance as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual sensory, or health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) inappropriate types of behavior or feelings under normal circumstances; (D) A general pervasive mood of unhappiness or depression; (E) A tendency to develop physical symptoms associated with personal or school problems. Additionally, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted.

Missing from the IDEA definition of SED is social maladjustment. Social maladjustment refers to a pattern of destructive, aggressive, antisocial and delinquent behavior (Merrell & Walker, 2004). The exclusion of social maladjustment from the IDEA definition creates a gap and loophole in which many children who would otherwise be labeled as SED by DSM based definitions are overlooked, unidentified and never exposed to services which could alter trajectories and outcomes for the better (Merrell & Walker, 2004). These varying definitions are quite significant when understanding that schools are often the main catchment areas for students with emotional and behavioral issues. By schools excluding social maladjustment from their

definition it lowers the chances of some children with an SED becoming identified and receiving initial treatment for their various conditions (Lee & Johnson-Reid, 2009). Thus, no uniform definition of what is an SED continues to negatively impact the efficiency of treatment for this population of children.

Merrell and Walker (2004) discuss that SED is not a condition that can neatly be packaged into distinguishable clusters of behaviors. There is no predictable profile of how a child with an SED presents. A child with an SED can demonstrate anxious, depressed, oppositional, and anti-social tendencies, and these behaviors do not often occur in isolation. Numerous studies have found that co-morbidity occurs between internalizing and externalizing behaviors in children (Davis, Sheber, & Hops, 2002; Gresham, Lane, & Lambros, 2000). Cullinan, Evans, Ryser and Epstein's (2003) study comparing elementary school students with and without a diagnosis of emotional disturbance (ED), as defined by the schools, demonstrated findings that contribute to the notion that there is no clear-cut picture of how an emotional disturbance presents. These researchers examined approximately 900 students with and without an emotional disturbance and found that students diagnosed with an ED presented with high levels of co-morbidity. These researchers revealed that children diagnosed with an ED and presented with co-morbid characteristics were found to have a higher incidence of maladjustment and lower overall competence, suggesting that this population might be in need of more support in schools than is presently available to them.

Lack of uniformity surrounding the means by which professionals identify an emotional disturbance can cloud identification as well as the conceptualization for the direction and implementation of school-driven treatment plans. This can become a problem as early identification and symptom severity have been shown to impact treatment outcomes (Fergusson, Horwood & Ritter, 2005, & Frick, Cornell, Barry, Bodin & Dane, 2003, & Liber et al., 2010).

If children with an SED are not identified in the schools, there is more pressure on the community to identify these children and administer adequate services. However children's

mental health agencies are often ill-equipped to provide appropriate services that help to maintain these children in their home communities where family, resources, and supports are more readily available (Hazell et al., 2002). Furthermore, Wagner et al. (2005) found in their study in children with an SED there is a significant “lag” in service, meaning even after the child was identified as having an emotional disturbance there was an approximate span of two years until services began. This “lag” was found to be one year more than the span of time children with other disabilities had to wait before they received service provisions. It was also found that children with an SED were less likely to receive any intervention services than children with other disabilities. Early identification and intervention have been found to be essential in the treatment and maintenance of stability in the child with an SED population (Wagner et al., 2005). Unfortunately due to a scarcity of appropriate community and home-based services for children with an SED their available resources are frequently housed in more restrictive settings (i.e. residential placements, acute-care hospitalizations) that do not naturally lend themselves to helping these children manage their issues in the settings where they occur (Anderson & Mohr, 2003).

### **Trajectories for the SED Population**

This next section will examine trajectories and outcomes for children with an SED. As previously mentioned these youth are often an under identified population. This may cause dangerous complications, due to the numerous risk factors associated with this diagnosis (Kauffman, 1999).

Anderson and Mohr (2003) state that children with an SED have problems across all aspects of life including, emotional and behavioral functioning, educational functioning, socialization and overall functioning. This makes them a vulnerable population to succumb to risk factors. Children diagnosed with an SED have disproportionately higher rates of dropout and academic failure, and they are more likely to be arrested, poor, unemployed, involved with illicit drugs and become teen parents (Kauffman, 1999). Specifically, some studies estimate that nearly two-thirds of the SED population fails to complete high school and that nearly 60% have been

arrested at least one time (Wagner et al., 2006). Wagner et al. (2005) elaborate on the multiple risk factors often present in the homes of children with an SED. Specifically, they concluded in their research that approximately one third of these households earned below the poverty level and a fifth of these homes had an unemployed caregiver that had not completed high school. Additionally, they found that approximately half of these children with an SED lived in a household with another person who had a disability. These studies illustrate the complex nature of the multi-stressors that impact this population of children. The cumulative effect of these multiple risk factors on SED caregivers and children is far-reaching over the course of their lifetimes.

Bradley, Henderson and Monfore (2004) performed a study in which they examined data on outcomes of children with an SED from three federally funded studies. Results of their study revealed that just over 8% of students with disabilities are identified as having an emotional disturbance. Among their findings was that students with an SED are placed in more restrictive settings than other students with disabilities. Students with an SED received the highest proportion of failing grades and predominantly scored in the low range on social skills assessments. Regarding classroom behavior, these students scored lower than any other special needs populations, including children with Autism. Nearly 75% of students with an SED have been expelled or suspended from their respective schools, compared with 22% of same age students from the general population. Additionally, 35% of students with an SED in the study had been arrested compared with 13% from all other students identified as having a disability. Overall these students had the worse outcomes, both academically and socially of any disability group. In conclusion, the authors stated that students with SED trajectories are dismal with little hope of change unless there is a renewed and comprehensive effort to address this population's vast spectrum of needs.

Continuing the discussion on the trajectories and outcomes of SED children, Wagner and Davis (2006) reviewed the data from a national longitudinal study of students receiving special

education services. This study examined a population of middle-school and high school students comprised from 501 nation-wide school districts. The researchers attempted to use a sample of school districts representative of national averages for all the disability and non-disability categories, including SED.

Results of Wagner and Davis' (2006) study reveal that children with an SED were less likely to have positive interactions with peers or to participate in activities with peers. Additionally, these children were less likely to attend a general education school or a school in their home community. They were less likely to participate in extra-curricular or group activities; thus, limiting their interactions and opportunities to share in general pro-social norms of such groups. Additionally, in terms of academic needs, although children with an SED stand to benefit from receiving mental health and behavior management services as well as social skills training or life-skills training, the majority of these children did not receive these services. In fact, school staff members most commonly reported unmet needs for these types of services for children with an SED when compared with every other disability group. In terms of future and transition planning, children with an SED workload was similar to that of general population students, while rates of vocational course-taking was significantly lower when compared with general population students. This ratio is not in line with the requests of the children with an SED within this sample, which revealed that they request more vocational training and less mainstream academic curriculum. An obvious limitation of this study is that findings are restricted to the schools evaluated within the study (Wagner & Davis, 2006).

The findings continue to underscore poor trajectories and outcomes for individuals diagnosed with SED as they transition to adulthood. Zigmond (2006) conducted a 2-year longitudinal study examining the experiences of students with an SED as they transitioned out of high school into the real world. Results indicated that underserved children with an SED out of high school are at the mercy of the unpredictable circumstances of life. These children's conditions, therefore will predispose them to a variety of risk factors if schools, communities

and/or transition services do not adequately meet their needs and prepare them for life as an independent and productive adult.

As the aforementioned cited literature demonstrates outcomes and trajectories for the SED population are often bleak. However research on treatment outcomes for children with an SED suggests some promising interventions that have been shown to reduce symptoms, teach social skills and promote pro-social behavior.

Considering the heterogeneous nature of the population with an SED, traditional single factor treatment models that only address primary symptom reduction will fall short in meeting the needs of this multi-faceted and unique population (Anderson & Mohr, 2003). Service providers must take into account developmental factors, such as age of onset, as well as numerous ecological factors, such as family instability, and parental stress (Anderson & Mohr, 2003).

Fite, Greening, and Stoppelbein (2008) propose a transactional model as a theory to explain the association between childhood behavior problems and parenting stress. The transactional model purports that children who are predisposed to act out or demonstrate behavioral problems increase the parental stress experienced by the caregiver, while the heightened stress level experienced by the caregiver perpetuates the behavior problems demonstrated by the child. Hence, service providers and subsequent treatments need to address and cater treatments to account for the numerous developmental and ecological factors facing a child with an SED (Anderson & Mohr, 1999).

In Ritchie and Holden's (1998) study on parenting stress in low income and abused women, they examined approximately 60 caregivers recruited from a local shelter for battered women from a low income area and a comparison group from the same low income community. They found that parenting stress was associated with a number of parenting variables including being less proactive with their children, setting fewer limits, providing less physical affection and less positive reinforcement. Additionally, they found that as caregivers become more stressed they are less attuned and attentive to their children, more easily distracted from parenting

behaviors and within the realm of discipline they become more punitive and reactive regardless of being battered or not. These findings illustrate the profound impact stress can have upon parenting as it can moderate the effects of domestic violence. The authors state parenting stress has a direct path to a parent's inability to demonstrate pro-active and preventative behaviors with their child as they can't sufficiently monitor and regulate their child's behavior while experiencing significant caregiver stress. Research has also demonstrated that caregivers of children with an SED have been found to experience more stress than caregivers of children without the SED diagnosis (Morgan, Robinson and Aldridge, 2002). Hence, examining parental stress in relation to children's behavior and impact on treatment outcome will be a focus of this literature review.

### **Internalizing, Externalizing and Callous/Unemotional Behaviors and Social Skills**

The following portion of this paper will review four distinct areas of behavior that many children with an SED demonstrate or struggle with: internalizing behavior, externalizing behavior, antisocial callous/unemotional traits and social skills. It will also examine those variables that have been shown to impact outcomes and adjustment. Specifically, the following portions of this review will examine the areas of symptom severity, treatment outcomes and parenting stress with respect to internalizing behavior, externalizing behavior, antisocial callous/unemotional traits and social skills. Although children with an SED often present with co-morbid characteristics across these areas, many treatment models are designed to address primary diagnoses.

### **Internalizing Behaviors**

Internalizing disorders are problems that appear to be related to issues occurring within a person. In these types of disorders, children's symptoms are acted out upon oneself rather than upon the environment. Some internalizing behaviors may include depressive and self-loathing thoughts, anxiety, fears, physical or somatic complaints, worrying, and shyness. Some refer to this cluster of behaviors as "overcontrolled, overinhibited" and "shy-anxious" problems