REPORT OF AN INTERNSHIP COMPLETED AT THE CALGARY LEARNING CENTRE

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by

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Abstract

This report describes an internship at the Calgary Learning Centre. The report details the internship and a research component which was completed at the internship site. The goals of the internship included: development of psychometric skills and report writing, development of individual counselling skills, increasing the knowledge of current intelligence, interest, achievement and diagnostic instruments and conducting research on the effectiveness of the problem solving strategies used at "Camp ADDventure".

The twelve week internship was completed at the Calgary Learning Centre, located in Calgary, Alberta. There was extensive opportunity to meet with the professional staff about services offered at the Centre and to gain insight into the varied theoretical perspectives of each psychologist. Throughout the placement the intern met with and provided psycho educational assessments with four staff psychologists.

Much of the intern's time was devoted to researching the effectiveness of problem solving strategies used at Camp ADDventure on increasing socially-appropriate and self-corrective behaviours in children diagnosed with AD/HD.

For my grandmother, Rita Parsons, and for all those who encourage the life-long pursuit of knowledge.

Acknowledgements

I extend my sincerest thanks to the Calgary Learning Centre and the staff who participated in this study. I would especially like to thank my on-site supervisor, Dr. Anne Price, and my faculty supervisor, Dr. Gary Jeffery, for their support and guidance. Last, and perhaps most importantly, I extend my thanks to the parents and children who participated in Camp ADDventure and so willingly allowed me to conduct research.

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Part 1

INTERNSHIP COMPONENT

Rationale for Internship

The decision to do an internship came after much internal debate and deliberation. Guiding the intern's thoughts were many factors, including the opportunity to work with experienced psychologists and to receive further guidance in shaping her own skills as a psychologist. Much of the intern's past experience has been in experimental psychology so an internship affords an excellent opportunity to develop applied skills in anticipation of a career. The main goal of the internship was to further enhance the intern's skills as a would be psychologist. The intern also sought insight into the concerns of professionals working with children/adults who have been diagnosed as having AD/HD and/or learning disabilities.

This interest was reflected in the project completed during the internship.

Introduction

Memorial University of Newfoundland offers a number of options to those seeking to complete the Masters of Education (Educational Psychology) program. The options are a thesis, project, paper folio or an internship. The internship period is ten to thirteen weeks in which the intern gains practical experience in their chosen field of study. During this time the intern will work toward achieving individually set goals while receiving continuous feedback from the faculty and on-site supervisors.

Specific criteria have been outlined by the Faculty of Education to ensure the appropriateness of the internship as a supplement to the academic and professional training for the psychologist.

1. It can commence only after satisfactory performance is achieved in an approved practicum.
2. It commences only after successful completion of all course work required for the degree program as defined in the University Calendar.
3. First consideration will be given to candidates who have had little experience in the working milieu they will enter.
4. Interested students must submit and have approved by the Faculty of Education, a formal internship proposal, including among other points, a statement of professional goals and expectations for the internship.
5. An intern must be enrolled full-time during the time of her internship. She may not receive reimbursement for services rendered during internship but will be eligible for fellowships and assistantships as provided by university regulations (Faculty of Education, 1996).

Criteria for Selecting Internship Setting

The guidelines for the Internship Programme, as outlined by the Faculty of Education (1996), state that the intern should work with a wide variety of clientele to further enhance skills in an area or with a population in which the intern will work in the future. When choosing a setting, one must assess the following considerations:

1. The quality of professional supervision.
2. The quality of learning opportunities and experience.
3. The relevancy to, and usefulness of such experiences in the actual setting in which the intern ultimately expects to work.
4. The availability of time for full-time involvement of the intern for a minimum of 10 consecutive weeks.
5. Availability of a qualified field supervisor on-site.
6. Ready access to the university supervisor.

Provision should be made whereby the intern has opportunity to integrate theory and practice under the guidance of skilled practitioners.

Description of Internship Setting

What follows is a description of the internship setting chosen, a list of staff employed at the setting, and the services provided by the setting.

The Calgary Learning Centre (CLC) was the chosen site for the internship placement. This site was chosen for the following reasons. It offered:

1. Quality learning opportunities and experiences. Included were opportunities to use and study a variety of psycho educational assessment administrations and styles of report writing.

2. The opportunity to work as part of an interdisciplinary team which consisted of trained psychologists, social workers, educational consultants, and a paediatrician.

3. The opportunity to participate in Camp ADDventure with skilled professionals (for example, psychologists and counsellors).

4. The opportunity to work with both children and adults with possible attentional or learning disabilities.

5. The opportunity to direct initial intake interviews for adults interested in counselling or assessments for learning/attentional problems.

The Calgary Society for Students with Leaning Disabilities operates The Calgary Learning Centre (CLC), which is a non-profit, charitable organization located in Calgary, Alberta. It opened in December, 1979 with the primary goal of improving services for people with learning difficulties. The Calgary Learning Centre is a joint project of the Alberta Children's Hospital, Alberta Vocational College, Calgary Board of Education, Calgary Catholic Board of Education, Calgary Health Services, Kinsmen Club of Calgary, Leaning Disabilities Association of Alberta (Calgary Chapter), University of Calgary and Friends of the Leaning Centre. Support for The CLC comes from Alberta Education, the sponsoring agencies, specific project grants from local, provincial and federal agencies, fees for service and donations from the community. The mandate of The CLC is threefold: research, professional development and service to clients. These three spheres of activity are carried out in a highly integrated manner to ensure continuity between knowledge generated in research, experience gained in client service and the content of professional education program

List of Staff Employed by Setting

Below is a list of staff at the CLC, which in some cases includes a listing of special interests of the staff member (Asterisks indicate persons the intern worked most closely with):

*Anne Price (Executive Director)

Chartered Psychologist

*Shawn Crawford (Chartered Psychologist)

Adult and children learning assessments

Counselling both children and adults

Kimberly Eckert (Chartered Psychologist)

Counselling both children and adults

Adult and children assessments

Oppositional defiant disorder

Giftedness

Neta Howard (Chartered Psychologist)

Contractual

*Rita Humphreys (Language/Learning Clinician)

Reading, language, learning mainly with children

Gillian Hutton (Psychologist Assistant)

*Melanie Loomer (Chartered Psychologist)

Adult or children ADD cases

Emotional assessments

I.Q. testing

Counselling

Susan Maunula (Chartered Psychologist)

Contractual

Children assessment

Attention clinic

Karen Serret (Chartered Psychologist)

I.Q. tests

Consultation

*Noella Piquette-Tomei (Educational Consultant)

Adult, adolescent, child educational issues

*Gayle Reid (Educational Consultant)

Adult learning assessments

Reading, learning

Simone Shindler (Social Worker)

Adult or children ADD cases

Family interviews

School observations

Attention clinic

Counselling adults and families

Geraldine Farrelly (paediatrician)

Attention clinic

Description of Services Provided by Setting

The CLC in it's **Policies and Procedures Manual** (1996) lists and describes the following services:

Intake - The purpose of the intake service is to provide information to prospective clients, friends, parents and professionals about Calgary Learning Centre services and the appropriateness of a referral here. Depending on client needs, the callers may be directed elsewhere. Calls are initially screened by the Intake Worker.

Assessment - A multi-disciplinary staff is available to provide assessments on a fee-for-service, or contractual basis, to clients from the ages of 5 to adulthood, to explore reasons for difficulty in school or in the workplace. Assessments which are focused on a particular area (such as reading, attention, numeracy, language) may require 8-10 hours while full in-depth assessments can take up to 15 hours. This time includes preparation, assessment, report-writing and feedback. It usually takes approximately 6 weeks from the time of the first appointment to the feedback interview, unless otherwise arranged.

Consultation - This service is offered on a fee-for-service, or contractual basis, to clients, family members, employers and/or other professionals who wish to consult with a member of the Client Service Team. Reasons for this may be a desire on the part of the client for "advice" as to the type or location of the most appropriate service. Often clients

will have previous assessment data which can form the basis for the problem-solving. Consultations to professionals may concern interpretation of behaviour or test data of one of their clients. This service can be carried out on-site (e.g. at a school, workplace, or other institution) at the CLC, or on the telephone, if previous financial arrangements have been made.

Programs - Many programs are offered at the CLC to children and/or their parents, to adults and their spouses as well as to professionals. They are based upon client need, interest, and the availability of staff expertise. Some are offered free-of-charge, but for most programs fees are charged.

Counselling - Services are available on a fee-for-service basis for individuals and families whose learning and/or attention issues impact heavily on their daily functioning. Calgary Learning Centre staff are also available to consult with counsellors, social workers, and psychologists who are counselling individuals with learning difficulties, in order to promote professional development in this area.

Tutoring - Services are available for kindergarten to adult. Individual tutoring and small groups are offered.

Attention Clinic - Provides a range of services to families of children/adolescents who have attentional difficulties and who are faced with a unique set of problems: academic, social/emotional, behavioural, and medical. Services include a diagnostic service,

treatment planning, referral, school consultation, and medical intervention.

Supervision of Intern

The supervision of the internship was the joint responsibility of Dr. Anne Price and Dr. Gary Jeffery. As outlined by the Faculty of Education (1996), the selected field supervisor met the following criteria:

1. She possesses a Master's Degree or its equivalent appropriate to the work of the intern, or equivalent and appropriate experiences as determined by the Faculty of Education.

2. Had a minimum of two years experience in the field as determined by the Faculty of Education.

3. Was involved full-time in the placement setting.

4. Had sufficient time, as determined by the Faculty of Education, to consult regularly with the graduate student.

The University supervisor met the following criteria:

1. Was professionally trained in the area of school psychology and indicated an interest in psychology training.

2. Had sufficient time, as determined by the Faculty, to consult regularly with the intern.

3. In consultation with the field supervisor was responsible for directing the preparation and evaluation of the report on intern activities.

Personal Goals for the Internship

The internship was completed primarily because it allowed the intern the opportunity to gain further experience and professional competence in the field of psychology. The intern identified eight goals for her internship placement. The following is a statement of these goals along with a description of activities undertaken to meet these goals.

Goal 1: To gain further practical experience in psychological assessment and report writing.

This goal was accomplished through the following activities;

(1) The intern observed (for about 10 hours) other staff psychologists administer a variety of tests, some of which included the WISC-III, WIAT, and the Standard Progressive Matrices (dynamic administration vs. standardized administration).

(2) The intern reviewed reports prepared by other psychologists. Approximately two reports per week over four weeks were reviewed.

(3) The intern was active in the administration and scoring of both previously administered tests and a number of previously unfamiliar tests. The intern administered three WISC-III, two WIAT, one Leiter, one Piers-Harris, two Kaufman Test of Educational Achievement (K-TEA) and one Social Skills Rating Inventory (SSRI) assessments.

The intern was also active in the interpretation and report-writing associated with these assessments in consultation with psychologists. The intern planned and completed two psychoeducational assessments which consisted of a complete battery of tests including measures of achievement and intelligence. The intern also explained results of assessments to parents. Psychological reports included recommendations and were forwarded to the referral source.

Goal 2: To gain experience as a member of an inter disciplinary team.

(1) The intern worked in consultation with the social worker, educational consultants and other psychologists.

Goal 3: To conduct field observations.

(1) The intern conducted four classroom observations, interviewed the teachers and wrote the accompanying reports.

Goal 4: To gain experience in "Intake Procedures", as related to individual screening.

(1) The intern conducted 24 adult intake interviews from May 27 - June 13, 1997.

Goal 5: To have field supervision.

(1) The intern met weekly with field supervisor for one hour. As well, incidental contacts with the field supervisor occurred on a regular basis.

Goal 6: To gain experience in the administration and organization of a non-profit agency setting.

(1) Staff meetings were attended on a bi-weekly basis. The agenda usuallyI included approval of prior minutes, business arising from minutes, correspondence, current reality, staff reports, assessment updates, future programs/workshops, and committee reports (client services technology, consultation, ethics, intake, library, programs, social, and staff development).

Goal 7: To learn about the nature and treatment of children diagnosed as having Attention Deficit/ Hyperactivity Disorder (AD/HD).

(1) This goal was met through the study which the intern conducted (see Part 2 of this report), and by day to day contact with AD/HD children.

Goal 8: To complete a study on the effectiveness of problem solving strategies on increasing socially appropriate and self-corrective behaviours in campers. A report of this research can be found in Part 2 of this report.

This goal was accomplished through the following activities:

(1) An independent study of strategy development in AD/HD children was conducted three days a week for three weeks at the internship site. The literature review consisted of examination of journals, articles and books related to the use of problem solving strategies with children who had been diagnosed as AD/HD.

(2) The intern presented on the topic of her research to parents of children attending Camp Addventure.

(3) The intern attended Camp ADDventure three days a week at the CLC. During this time she collected data on the effectiveness and the use of problem solving strategies in increasing socially appropriate and self-corrective behaviours in AD/HD children who were attending the camp.

(4) The intern analyzed data collected from the Camp members and counsellors and completed the report found in Part 2.

Conclusion

The Calgary Learning Centre is an excellent placement for students in the Educational Psychology Masters Degree program. Individuals can meet requirements as set by the Faculty of Education and one can achieve a broad range of individualized goals in developmental psychology and psychoeducational assessment. The internship allowed the intern to become familiar with the delivery of services in a non-profit setting and provided the opportunity to work with members of an interdisciplinary team. Through this setting the intern gained many valuable learning experiences which prepared the intern for future work in the practice of psychology. The intern found, in general, that an internship offered unparalleled learning experiences and preparation for work as a professional. However, students considering completing an internship in another province should recognize the main difficulty that distance presents, communication. A faculty supervisor is not always easy to reach if there are time differences between different

provinces. However, with the increasing use of electronic communication (e.g., fax, E-mail) this becomes less of a problem. As well, ensure that time is allotted for report drafts to be received and returned through the mail.

PART 2

Increasing Socially Appropriate Behaviour in AD/HD Campers: A Study of the Effectiveness of Problem-Solving Strategies

2.1 Overview

This study should be considered a "pilot" study to identify variables which may be used as a part of perhaps a later larger and more formal evaluation. Unfortunately, little is written about the impact and success of camp based programs in general. This study hopefully adds to the research in this area and is useful for informing the CLC about restructuring and supporting the camp.

The purpose of this study was to record the effectiveness of coping strategies, taught at camp, on increasing the socially appropriate behaviours of children diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD). Throughout the camp, behavioural information was gathered on a sample of 19 children in the form of observation samples and counselor comments. The frequency of target behaviours, that is the number of times each child displayed socially appropriate or self-corrective behaviours, was gathered through observations. Socially appropriate behaviours were defined for the purposes of this study as behaviours which society deems as appropriate or desirable, for example, turn taking in conversation or activities, sharing of resources, and helping others. Self-corrective behaviour was defined as a child realising an inappropriate behaviour or mistake was made by themselves and correcting it spontaneously, without being reminded by outside sources, e.g., camp counselors.

Examples of inappropriate behaviours included, hitting, pushing, yelling or refusing to share resources with others.

Rationale for Research Component

The CLC is involved in research on causes, assessment and treatment of learning difficulties. The Centre also offers services to children and adults. These services include assessment, individual and group treatment programs and consultation. In particular, the CLC offers programs including attention clinics, workplace literacy services, tutoring services, and a three-week camp for children with Attention Deficit/Hyperactivity disorders.

Staff members include three full time psychologists, four contract psychologists, two educational consultants, one social worker, one speech and language clinician, two contract occupational therapists, two intake workers, and two paediatricians.

Staff at the CLC identified that they were interested in having research carried out on the effectiveness and impact of the camp. It was hoped that research might aid future decisions about restructuring and supporting the camp.

Research Questions

This study was aimed at evaluating the effectiveness of the camp program and experience for enhancing coping strategies and increasing socially appropriate (Barkley, 1990) behaviours in AD/HD children attending Camp ADDventure.

In evaluating the effectiveness of these strategies the following questions were addressed:

1. What is AD/HD?
2. What are socially appropriate behaviours?
3. What are self-corrective behaviours?
4. What is the purpose of Camp ADDventure?
5. What sort of training do the counselors receive?
6. What kind coping strategies do the counselors use with the campers?

2.2 Review of the Literature

The Wildest Colts Make The Best Horses

-Themistocles, 512-499 B.C.

Description of Children With Attention Deficit/Hyperactivity Disorder (AD/HD)

It is quite normal for children to be more active, more exuberant, less attentive, and more impulsive than adults. It is hardly surprising that children have more problems than adults in following through on directions and consistently finishing their work. When parents complain that their child has difficulty paying attention, controlling his or her activity, or resisting impulses, others may be quick to dismiss these problems simply as normal behaviour, and reassure parents that these are natural qualities of children, that there is no need for alarm. If a child's behaviours seem a little excessive, even for a child, it is too often assumed to have been the case that he or she is simply a little immature, and will likely grow out of these problems (Barkley, 1990, 1995).

Usually it is true that children will outgrow these problems. There are times, however, when it is not true. In some cases a child's attention span is so short, activity level so high, and impulse control so limited that his/her behaviour in these areas are clearly extreme for his/her age (Barkley, 1990). Most people have known such a child, one who is having trouble completing schoolwork and not be getting along well with the neighbourhood children, a child whose inability to follow through and complete assigned chores without parental supervision is causing conflict at home.

Behaviour problems in these areas that are so severe as to impair a child's adjustment are not likely to be outgrown, can hardly be considered normal. Children with significant problems with attention, overactivity, and lack of inhibition reach a level have a developmental disability known as Attention Deficit Hyperactive Disorder or ADHD. Children whose primary problem is attention without evidence of overactivity have Attention Deficit Disorder or ADD (Barkley, 1995; Woodrich, 1994).

Attention Deficit/Hyperactive disorder (AD/HD) is a neurological condition that affects learning and behaviour which occurs in approximately 5% to 10% of the population, depending on the scientific studies you review. Symptoms of the disorder may include attention deficits, impulsivity, hyperactivity, mood swings, low frustration tolerance, and difficulty falling to sleep at night (Barkley, 1995; Quinn, 1994). It is important to distinguish ADHD from other disorders that may include similar symptoms such as hyperthyroidism or conduct disorder. The Diagnostic Statistical Manual: 4th Edition (DSM IV, American Psychiatric Association, 1994) is a helpful tool that many clinicians use to decrease the possibility of an inappropriate diagnosis (see Appendix 1 for the DSM IV definition of AD/HD).

Recently, scientific studies have suggested that AD/HD is not primarily a disorder of paying attention but one of self-regulation (Barkley, 1995; Braswell & Bloomquist, 1991). Thus, AD/HD children are rarely judged as significantly more active than others in free play situations but are frequently observed to be so in more structured interactions or classroom observations (Braswell & Bloomquist, 1991).

Recent research in the area of AD/HD has dispelled many of the misconceptions formally held. For example, the following past beliefs about AD/HD have been challenged by Barkley (1995), a leading expert in the field. He points out that it was believed that AD/HD was caused by brain injury or poor parenting; that children would eventually outgrow it by adolescence; that stimulant medications would be effective only with children (not with adults or older adolescents) and only on school days; and that AD/HD children would benefit from a diet free of certain food additives and sugar. Recent research suggests that AD/HD is part of an internal mechanism in individuals with the disorder (Barkley, 1995; Braswell & Bloomquist, 1991).

Psychostimulant medication is the most common treatment for children with AD/HD. Psychostimulant medications are so named because of their ability to increase the arousal or alertness of the central nervous system (CNS). The three most commonly employed CNS stimulants are Ritalin, Dexedrine and Cylert (Barkley, 1990).

Ritalin, **methylphenidate hydrochloride,** is the most commonly used medication for attention disorders, the one most frequently tried first, and the one generally considered the safest. It is available in generic form in 5 mg., 10 mg., and 20 mg., tablets. Ritalin is available in a short-acting tablet (5 mg., 10 mg., or 20 mg.) which lasts approximately three to five hours and it is also available in a long-acting sustained release tablet that lasts approximately seven to ten hours. Ritalin is typically initiated in small doses, usually at 5 mg. Ritalin-Slow Release (SR) is often utilized after the therapeutic dose level has been determined. Ritalin-SR is available in only one size, 20 mg. (Copeland, 1991).

Dexedrine, **dextroamphetamine sulfate,** is the medication of choice for those children who are unresponsive to Ritalin. It is the only psychostimulant approved for children under the age of six. A generic form is available in 12.5 mg. and 20 mg. Dexedrine is available in a short-acting, four hour, tablet form only in a 5 mg. size. The sustained release form, Dexedrine, Spansule, is available in 5 mg., 10 mg., and 15 mg. capsules. Dexedrine also comes in an elixir, Dexedrine Elixir. One teaspoon (5 ml.) is equivalent to 5 mg. (Copeland, 1991).

Cylert, **pemoline,** is the newest stimulant on the market. Cylert is supplied as tablets containing 18.75 mg., 37.5 mg., and 75 mg. of pemoline. It is also available as chewable tablets containing 37.5 mg. of pemoline. It is currently not available in generic form. Cylert was formulated to be administered once a day. When discontinued, the medication requires several weeks to fully dissipate from the bloodstream. Since it does have a build-up effect, it should be discontinued gradually, unlike Ritalin and Dexedrine which can be fully discontinued at once. Side effects, such as liver dysfunction, and that it lacks the degree of positive benefit achieved with Ritalin or Dexedrine make it a third or fourth choice medication for most physicians (Copeland, 1991).

Approximately one million of the school-age population in the United States take medication annually for management of their attention deficit symptoms (Copeland, 1991). When the medication works as it is designed to, there is improvement in a child's ability to attend and in his/her impulse control, behaviour, cooperativeness, reasonableness, and sensitivity to social cues and expectations (Copeland, 1991). The goal of all medications used to treat AD/HD is the normalization of attention, focusing and behaviour. When drugs "work", a child will simply accomplish whatever his/her

goals are more successfully on medication than off.

The ability of medication to decrease negative behaviour and enhance positive, more appropriate behaviour has been demonstrated. Children on medication are more co-operative; they talk out inappropriately in class less; they interact less aggressively with peers; and attention-getting behaviours decrease (Barkley, McMurray, Edelbrock, & Robbins, 1989)

Medication alone is not enough to treat children with AD/HD. For example, Kavanaugh & Truss (1988), who have studied attention disorders for over two decades, found that adolescents who received psychological and educational assistance, in addition to medicine were significantly better adjusted than those who received medication alone. It appears that medication enables an AD/HD child to benefit from interventions which are ineffective in the absence of the medication.

According to Braswell & Bloomquist (1991) AD/HD can be conceptualized as an inability to modulate one's activity level to match the demands of the environment. Barkley (1995), takes this idea one step further and argues that AD/HD is really a disturbance in the child's ability to use self-control with regard to the future. He proposes that children with AD/HD suffer from an inability to use a sense of time and that they are less able to use a knowledge of the past and future to guide their behaviour. What is not developing properly is the capacity to shift from focusing on the here and now to focusing on the future. Based on these views, it is likely that children with AD/HD should benefit from strategies that help them to focus on thoughts that precipitate actions. Behaviour management based problem solving approaches or cognitive behaviour therapy often encourage strategies of a type potentially useful to AD/HD children.

Social Skills: Problem Solving Approaches to Behaviour Management

AD/HD children are at high risk for peer rejection. This appears to be due to their tendency to display a relatively high rate of immature, bothersome, or even aggressive behaviour while also showing problems in their social maturation, particularly with respect to prosocial skills. These problems with peer relations frequently result in low self-esteem, loneliness, and even depression in those experiencing rejection (Landau & Moore, 1991). Moreover, the risk for maladjustment in later life appears to be significantly increased by poor childhood social relations (Barkley, 1990; Hallowell & Ratey, 1994; Landau & Moore, 1991). Intervention programming that involves the learning and generalization of socially appropriate behaviours and self-monitoring is crucial to AD/HD children. An example of such intervention is the use of problem-solving approaches as a part of a behaviour management program.

In general, problem-solving approaches to behaviour management stress the role of the client learning to (through thought) control his/her actions. They rely on the development of intrinsic motivation, and on the child learning to regulate his/her own behaviour. They also stress that the generalization of behaviour management solutions is initially time consuming (but becomes less so as child becomes self-regulated) and places responsibility with the caretaking adult and the child (Blakemore, Shindler, & Conte, 1993; Braswell & Bloomquist, 1991). Thus, in the problem solving approach the adult identifies the problem, gives descriptive feedback, provides alternatives, and allows the child to generate alternatives to make a choice (Haywood & Weatherford, in press). Some

strategies, outlined by Haywood & Weatherford, to teach children socially appropriate behaviours include: modelling, practice, positive feedback, social perception, relaxation, and cognitive approaches.

Modelling is defined by McGinnis and Goldstein (1984) as "learning by imitation" and has been shown to be an effective teaching method for children. Most social behaviours are learned through social modelling. Essentially, the child learns by observing a model who illustrates effective behaviour. The child does not, initially, become involved in practising the behaviour. It is presumed that, as a result of being exposed to the appropriate use of a skill, the child will show an increased probability of using or displaying the effective behaviour.

Although modelling is a useful component in the teaching of social skills, it is not enough to create the maintenance of skills or transfer to other environments. It is unlikely that behaviours will be remembered, repeated, and maintained if the child is not given the chance to practice them. Even though modelling and practice are considered highly effective ways of acquiring social skills, their effects often do not last (McGinnis & Goldstein, 1984). Even though a child may know what to do and how to do it. he/she typically requires an incentive to keep performing the act(s). Social reinforcement, praise or approval from others is important as it then allows the child to see exactly what behaviours are viewed as desirable by others. Positive feedback should be used whenever the goal is to strengthen and maintain a behaviour (Abramowitz & O'Leary, 1993).

It is also important to help children become aware of the impact of their own thoughts and feelings on social behaviours. Social perception is and involves understanding a social situation - knowing when and how to make an appropriate response (Haywood & Weatherford, in press).

Teaching the child how to relax is thought to enhance his/her ability to control thoughts and feelings that may interfere with his/her ability to perceive social situations accurately and therefore respond appropriately. A belief held by authors of several social skills programs (Haywood & Weatherford, in press; Landau & Moore, 1991) is that a child who can use relaxation techniques may be able to alter negative feeling states and delay impulsive expression of negative emotion long enough to think of alternatives.

Cognitive behaviour therapy or "Stop and Think" is a technique to help students problem solve more effectively, or to stop and think before they act. This type of therapy is particularly useful for students who are impulsive or lack self-control strategies. In cognitive behaviour therapy, students are taught to slow down and work through problems methodically rather than impulsively approaching tasks. In order to best understand the strategy, students are taught to first utilize this technique when completing academic tasks and later to use this technique in dealing with interpersonal and social situations (Blakemore, Shindler & Conte, 1993).

The steps of "Stop and Think" include teaching students to:

-define and recognize the problem (clearly understand the exact difficulty or requirements of the task),

-set goals (determine how students want things to end up),
-think of all the possible solutions to reach this goal and possible consequences of each of those solutions,
-focus, concentrate and choose the best or most workable solution and evaluate the performance (Blakemore et al., 1993) .

Students can be taught to use "Stop and Think" through self-instructional training, modelling, cues and a reinforcement system. Self-instructional training includes having students verbalize each of the steps employed in the program and become cognitively aware when considering and dealing with problems. By taking time to "just say" each step students will slow themselves down. According to Blakemore et al. (1993) students should be encouraged to say:

Let's see, what is the problem here? What do I have to do? I have to set a goal. How do I want things to end up? Now I have to think of all the possible ways to reach that goal and think of the consequences of each of my possible solutions. I had better focus and concentrate now and choose the best solution. Did this solution help me reach my goal and are the consequences good? Yes? Great, I focused and figured it out, (or) No, that solution did not work. I had better try again. How do I know I've finished? (Page, 7).

Eventually, students are encouraged to "fade out" the verbalizations and silently go through each step. The final step, evaluating, is particularly important in helping students recognize when tasks are completed correctly and realize that when mistakes are made, they simply need correcting (An example of a cognitive approach to problem solving can be found in Appendix 2).

Cognitive behaviour therapy is most effective when students are provided with reinforcement for using the strategy (Abramowitz & O'Leary, 1991). Reinforcement appears necessary for most students, both to learn, as well as to continue using the strategy. A camp, such as Camp ADDventure, provides an excellent opportunity to test this approach in the treatment of AD/HD. In such a setting AD/HD children could learn and practice cognitive strategies from models while receiving consistent positive reinforcement in a highly structured manner.

Value Of Summer Camps

Summer camps provide an organized setting in which children make new friends, acquire new skills, develop independence and responsibility, and have fun. Researchers have found that the camp experience promotes and enhances the development of three traits considered to be important to becoming a healthy, productive adult: positive self-esteem, strong self-confidence, and good social skills (Edelman, 1995). Building social skills is extremely important summer work for all children. Summer involves more socializing and self-planning than does the school year. A large percentage of individuals

with AD/HD have difficulty acquiring and applying social skills.

A camp program which is a highly structured, meaningful, and motivating experience can make an outstanding difference in inappropriate behaviour of all children (Zwaig, 1974). The logistic functions of a camp require the co-operation of all participants. Co-operation carries over into the classroom, facilitates peer interaction, and can be developed through activities designed to reward the team that is best able to function as a co-operative group.

At camp, AD/HD children are removed from parental anxieties about behaviour and achievement. They do not have to cope with the prejudices and stereotyping which adults and children in their community may have built around them. A camp provides a setting within which the campers can develop competence and confidence. The counselors do not demand of the campers that which they cannot accomplish, but they do encourage maximum achievement.

Improvements in children's self-concept following summer camps has been documented. For example, Roswal, Roswal, Harper & Pass (1985) studied 22 learning and mentally challenged students, 8-12 -years-old, enrolled in a summer day camp program. They found that the camp program did have a significant positive effect on the self-concept of the students. Similarly, Zemke, Knuth, & Chase (1984) found that attending a therapeutic summer residential camp led in improvements of self-concept in 16 learning and intellectually challenged children, aged 6-16 years.

Structure/Purpose of the Calgary Learning Centre (CLC) Camp

It must be made clear that it is not possible within the scope of the project being completed as a part of the Memorial University of Newfoundland M.Ed. requirement, to do a comprehension evaluation of the effectiveness of the camp program offered by the Calgary Learning Centre. What is possible, however, is an impressionistic description of the camp. From the researcher's perspective, two types of data were collected which were deemed to reflect key aspects of the program. The broad goal of this study is to assess the effectiveness of delivering a therapeutic camp based program aimed at developing self-correction strategies in children diagnosed as displaying the AD/HD syndrome.

This study focuses specifically on the gathering of data on the frequency with which the children display evidence of directly using these strategies by looking at the incidence, as observed by the counselors and the researcher, of socially appropriate behaviours in a specific summer camp milieu (Calgary Learning Centre camp).
It is hypothesized that the children will display an increase in socially appropriate behaviours as a result of an increase in their use of coping strategies taught at the camp.

Camp Addventure is a summer day camp setting for male/female children (ages 7-12 years) who have been diagnosed with AD/HD. University level male/female graduate students, usually from the Education faculty, are hired as camp counselors to work with the children (see Appendix 5 for individual profiles of camp counselors). Each counselor is responsible for a group of three-four children. The counselors are expected to guide and

support children through problem-solving situations. Counselors have the mandate to help children to be more accepting and knowledgeable about AD/HD, its impact on their lives, and to help them experience success throughout the camp experience. Counselors record their daily observations of the children's positive and negative interactions with others and the interventions that were implemented. Counselors also assist children in setting individual goals. Daily supervision is provided by the camp instructors. As well, counselors are involved in parent meetings (See Appendix 3 for camp weekly schedule and Appendix 4 for the camp brochure).

Training of CLC Camp Counselors

Pre-Camp

The training given counselors is aimed at developing practical knowledge and intervention strategies in the area of attentional difficulties in children. Counselors are involved in pre-camp instruction.

The pre-camp instruction involves one week of lectures on the nature of AD/HD, associated manifestations and intervention skills. Counselors are trained in the use of cognitive problem-solving style of behaviour management, and how to foster the development of social skills and anger management skills in the children. Role play and modelling activities are used throughout the pre-camp course. The training program offered is one developed by the CLC specifically for use with the counsellors.

On-Going Activities

Counsellors are involved in planning camp activities. During the camp, counselors are responsible for conducting activities, monitoring the behaviour of children and implementing the behaviour management approach. Counselors are expected to develop and monitor goals with individual children and keep records on children's progress and difficulties. Daily supervision of counsellors by program leaders is held throughout the camp period.

The program leaders are two staff members of the Calgary Learning Centre. A chartered psychologist and a psychological assistant were the program leaders for the 1997 camp.

After the camp, counselors are involved in follow-up sessions to debrief and reflect on the entire camp experience and to document the progress of individual campers. Each counselor also writes in-depth final reports on his/her group of individual campers. The report includes information gathered from camp observations (see Appendix 6 for an example of a final report).

2.3 Methodology

Overview

This section includes a discussion of the methodology involved in observing a group of AD/HD children during a three week day camp. Children were selected to attend camp ADDventure after a screening interview with the parents and the children themselves. Referrals for the camp come from two main sources. In some cases children had received services from the Learning Centre in the past, or in other cases, the parents had seen a brochure advertising the camp. All children had been previously diagnosed with AD/HD. The children that are identified as needing the benefit of the camp experience most were selected.

General Group Information

In all 19 children were selected to attend camp. They ranged in age from 7 to 11 years old (see Appendix 7 for individual profiles of campers). The children, six girls and 13 boys, were identified as needing help with social interactions and aggression control. They were also deemed to be in need of a greater awareness of their AD/HD. The small sample size was due to the fact that a limited number of children are admitted to the camp each year. The children selected to attend Camp ADDventure were a heterogeneous group. A number of children were experiencing other problems such as learning disabilities.

The camp commenced on July 7, 1997 and continued for three weeks. The camp sessions were held at the CLC. Facilities at the CLC include an outdoor playground, indoor classrooms, and a close proximity to outdoor swimming pools. This was a convenient place to meet since parents could drop off and pick up their children after each day. The day started at 9:00 a.m. and ended at 3:30 p.m., Monday to Friday.

Activities Offered at the Calgary Learning Centre Camp

The camp offered the children various structured and unstructured activities. In particular, AD/HD awareness classes, art therapy (see Appendix 9 for a description of art therapy), orienteering, swimming, karate, music, cooking, sports, and field trips were scheduled (See Appendix 3 for a copy of the camp schedule).

The frequency of target behaviours was gathered as observations. Information was also collected informally through field notes taken by the counselors, and camp screenings (see Appendix 10 for examples of informal field notes on campers taken by the counselors and Appendix 11 for examples of excerpts of conversation from the campers made during the camp on target days and noted in the counselors' field notes as representative of the general camp atmosphere at that time.)

Gathering of Data

Twice a day, three times a week, observations of each child were made. The researcher observed the target behaviours at different times throughout a day and across the week. Socially appropriate behaviours were focused upon. The failure to display socially appropriate behaviours was identified in the literature as a major area of difficulty for most children diagnosed with AD/HD.

Parents signed a consent form created by the researcher (see Appendix 8 for a sample of the consent form used) following a presentation by the researcher on the nature of the proposed study. All of the parents contacted agreed to allow their children to participate in the research.

Information on socially appropriate behaviours was attained during the pre-camp and camp phases. Each counselor and the researcher were responsible for tracking the frequency of occurrence of socially appropriate behaviours in a group of three or four children. Data was collected on days 3, 5, 6, 8, 10, 11, 13 and 15 of camp. The target behaviours of interest were socially appropriate and self-corrective behaviours. During camp training, counsellors were trained to recognise target behaviours and were checked periodically throughout the camp regarding the accurate use of these terms. Observations took place for fifteen minutes twice a day (at approximately 9:30 a.m. and 12:30 p.m.). The fifteen minute observations were timed using a stop watch. Counsellors carried a slip of paper to record the target behaviours as they worked. Counsellors only observed their own group of three/four children for each fifteen minute timed interval. Due to the

spreading out of children during different activities, the group of children that each counsellor observed changed between each timed interval. The total number of target behaviours in each of the two categories were counted in each group. On each day the 5 observers observed each of the four groups twice. A total of thirty-eight samples was collected on each of the observation days.

The types of "socially-appropriate" behaviours observed included turn taking in conversation, raising a hand before speaking, and praising or helping another camper with a task. "Self-correction" included any spontaneous correction of socially inappropriate behaviour, for example, talking out of turn and then raising a hand to speak, interrupting another speaker and then apologising for the interruption, and/or jumping ahead of someone in a line and then returning to the end of the line.

Anecdotal informal notes on counselor comments about the children's behaviours during the camp was also kept by the researcher. These notes were not formally analysed (see Appendix 10).

Analysis of Data

The number of "socially-appropriate" and "self-corrective" behaviours were compared in each category over the 8 target days (days 3, 5, 6, 8, 10, 11, 13, and 15). It was hypothesized that children would display an increase in socially appropriate behaviours and a decrease in self-corrective behaviours as a result of coping strategies taught at the camp. At the end of the camp, all of the counselors' and the researcher's observation samples were combined to ensure that data was available on each child attending camp. The frequency of socially appropriate and self-correction behaviours

observed in each child across each week of the three week camp by the counsellors and the researcher were combined into one pool to produce an overall mean for week one (based on a total two observation days), week two and week three (based on a total of three observation days). The significance of the differences between the means was analysed using a t-test (alpha level = .05).

2.4 Results And Findings:

Findings of Study

After reviewing the literature and the list of pre-camp activities it was felt by the researcher that the activities designed to be carried out in the camp and the preparation of the counsellors was deemed to be potentially beneficial to the campers.

The pattern in individual campers was compared at the beginning of camp (sample days 1 and 2) and at the end of camp (sample days 7 and 8). The comparison sought to find if after week one (orientation) there was a change. There were only 2-3 campers who "improved" while the others remained "unchanged" and one "got worse." If this comparison is legitimate, it would appear that the camp program had "no impact" on most individuals.

However, when all the frequency data from all the observations was combined across the three weeks some "trends" become apparent. According to the data displayed in Table 1 there appears to be an increase in socially appropriate behaviours and a decrease in self-correction displayed over the three week camp. Examples of socially-appropriate behaviour included raising a hand before speaking, turn taking, praising or helping other campers. Self-correction involved the spontaneous (i.e., without prompting from counsellors) correction of a socially inappropriate behaviour, for example, talking out of turn and then raising a hand before speaking or skipping in front of others in a line and then returning to the end of the line. None of the differences between days in either category reached statistical significance.

Though it can not be said that the camp experience was clearly related to an increase or decrease in the observed behaviours, trends are suggested in the data. In particular, week two of the camp was when the most socially appropriate behaviours (mean = 5.1) and the least amount of self-correction (mean = 0.1) were observed. During weeks one and three less socially appropriate behaviours (3.9 and 4.3 respectively) and more self monitoring (0.3 and 0.2 respectively) were observed than during week 2 (see Appendix 12 for a more detailed data table).

Table 1. Mean number of socially appropriate and self-corrective behaviours displayed by campers over three weeks.

	Socially Appropriate Behaviours	Self Corrective Behaviours
Week 1	**3.9**	**0.3**
Week 2	**5.1**	**0.1**
Week 3	**4.3**	**0.2**
Range:	**0 - 29**	**0 - 3**

Comments on Findings

There are few definitive comments that can be made on these findings. Perhaps week one is highly novel for the children so they "act up". Similarly, during week three they are busy preparing for the end of the camp and they know they will be leaving new friends, a familiar routine etc. and hence may "act up". However, during the middle of the

camp (week 2) they are settled into a routine and know the rules of the camp well. In this situation more socially appropriate behaviours may be more likely to be seen.

On the other hand, with self-correction the children are catching themselves when they make mistakes or poor social judgement calls. Thus, week one may involve a lot of self correction. In week two the rules are generally well known so less self-correction may be needed. By week three the children are aware that camp is ending so they may increase inappropriate behaviours and therefore increase the amount of self-correction they need to use.

Comments on Anedoctal Data

Throughout the camp, the counsellors and the researcher kept brief informal notes on individual campers. This anecdotal information suggested that, overall, the camp experience was a positive experience for the campers. It was the view of both the researcher and the counsellors that changes in target behaviours were noted by both counsellors and parents. Parents, counsellors, and campers openly expressed regret when the camp ended.

For the researcher, it was easy to see (for example, when the children and their parents were openly expressing regret and sadness that camp was ending) why there is general public demand and a long wait list for this camp every year. The program was well organized and accepted by campers, counsellors and parents.

2.5 Conclusions, Interpretations, And Recommendations

This pilot study sought to assess the effectiveness of a specially developed camp experience designed to enhance social interactions and self-corrective behaviours in AD/HD children.

To evaluate Camp Addventure the researcher collected information from the following sources: (i) literature review, (ii) counsellor rating and (iii) personal observations by counsellors and the researcher. Clear findings supporting the effectiveness of the program were not found.

Literature supported the need and legitimacy of support programs for AD/HD. In summary, the subjective, anecdotal data collected by the researcher also seems to support such a program. At the very least, the camp was deemed by parents, counsellors, and participants to be an enjoyable and qualitatively worthwhile experience.

Implementation of the camp observation consisted of two phases. The first phase occurred one week prior to the start of camp. This phase involved a great deal of effort on the part of the researcher. Before actual observations could take place, the researcher was faced with the challenge of presenting the proposed topic of research to parents of the campers in a coherent manner, requesting and collecting consent forms, assimilating information about each individual camper and training the counsellors how to record socially appropriate and self-correction behaviours. The second phase involved actual observations of the campers.

Evaluation of the campers' display of socially-appropriate behaviours and self-monitoring involved collecting data from the following sources: (i) timed interval observations, and (ii) counsellors' anecdotal notes. Based on the type and amount of data collected by the end of the camp, it is felt by the researcher that the observation process used during the camp should be modified if used in any subsequent formal study.

In particular, data collection times during the day could be increased from twice to three times. The increase in collection times might control for effects of AD/HD medication on children's behaviours throughout the day. It would also be helpful if the context of the activity the children are engaging in at observation times was noted. The researcher noticed that the frequency of socially-appropriate behaviours displayed by the children seemed to be somewhat directly affected by the level of stimulation provided by an activity (example swimming field trips were highly stimulating for the campers whereas the routine of craft making at the Learning Centre seemed to be not as interesting/stimulating for the campers). Therefore, low stimulation activities seemed to lead to a decrease in the amount of socially-appropriate and self-monitoring behaviours displayed by the children. When collecting subsequent data, the context/activity of the children must thus also be recorded. Significant interactions between social interaction and self correction of scheduled activities may exist.

As well, subsequent studies should include: more clearly developing "operational" definitions of target traits (including a distinction between "prompted" and "spontaneous" self-correction), making sure that the data collectors are not involved directly in camp activities, and having two observers observe the same campers for

reliability purposes.

Limitations of study

The pilot methodology tested by the researcher for the purposes of assessing the camp did not work well. Based on the findings of this study it is suggested that changes be made to the methodology of future studies addressing this or a similar issue. In particular, the following limitations in methodology were noted:

1. No interrater reliability established.
2. Short duration of camp.
3. Small number of campers attending camp.
4. Difficulty of defining socially appropriate behaviours and self-correction.
5. Campers often dispersed over a large area, hard to keep track of them during a fifteen minute time period.
6. Depending on activity (high stimulation such as swimming versus low stimulation such as small group discussion) campers' responses could vary. Future data could separate high stimulation activities from low stimulation activities.
7. Lack of control group for comparison.

In summary, according to the data collected, there appeared to be little or no change in individual campers as a result of the treatment program. According to the counsellors' views, there may be an increase in socially appropriate behaviours and a decrease in self correction displayed by the campers across three weeks. The researcher

felt that the problem solving strategies taught and used by camp Addventure may have an overall positive impact on the amount of socially appropriate behaviour displayed by campers. Given the small scope of this research project and the lack of statistical significance any implications drawn based on this data should be viewed with some caution. According to the research (Barkley, 1990; 1995; Landau & Moore, 1991) ways of enhancing social abilities is an important area of investigation in children diagnosed with AD/HD. There are some recommendations for those who might be interested in pursuing this research longitudinally.

To collect more definitive data one would need to increase the reliability and validity of the data by:

-Pre-testing campers three weeks prior to camp to establish a baseline of social skills.

-Testing campers three weeks post-camp to determine if there was a generalisation of problem solving skills to environments outside of camp.

-Collecting data from multiple samples, for example over the course of two or three years of Camp ADDventure.

Additional data should be collected to:

-Assess the impact of camp experience on younger versus older children.

-Assess the impact of camp experience on male versus female children.

-Assess the interaction between levels of stimulation (based on activities) and children's use of social skills (self-monitoring and socially-appropriate behaviours).

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APPENDIX 1 : Diagnostic Criteria For AD/HD (DSM-IV)

DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT/HYPERACTIVITY DISORDER as outlined by the DSM-IV

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) Six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

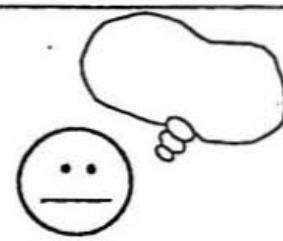
Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criterion A1 and A2 are met for the past 6 month

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months.

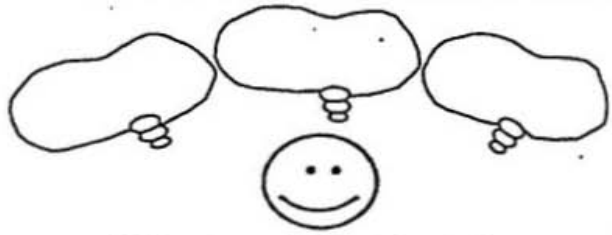
Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months.

APPENDIX 2: Example of cognitive strategy approach to problem solving

1. 



What is the problem?

2. 

What can I do about it?

3. 

Put a star on the "best" plan.

4. 

Do the plan!

5. 


Did your plan work?

APPENDIX 3: Camp ADDventure weekly schedule

CAMP ADD-VENTURE 1997

COUNSELLOR TRAINING SCHEDULE

	Friday June 27	Monday June 30	Wednesday July 2	Thursday July 3	Friday July 4
	-Getting to know you -About the CLC & Camp ADD-Venture -Tour -Policies and procedures - Carolyn Meier -ADD What Do We Know -Barkley Video -Diagnosis -Medications -Related Difficulties and Disorders -Karate	-Grief Cycle -Impact of AD/HD on family & child: academics, social/emotional -How Difficult Can It Be? Video -Planning	-Communication -Listening to feelings -Clear communication -Self esteem -Mediational Teaching -Problem Solving -Conflict Resolution	-Reactive Techniques -Choices and consequences -contracts -Camp Rules -Planning	-Crisis Intervention -Planning & Room Setup
	-Camp Schedules -Goal sheets -ABC Sheets -Camp Reports -Planning Activities	-Art Therapy - Marianne Snyder -Planning -About the kids and groupings	-Awareness (Talking to kids about ADD)- Melanie Loomer -Planning	-Music -Julie Freedman-Smith -Planning	-Planning -Team Building

CAMP SCHEDULE: WEEK 1

TIME	MONDAY 7	TUESDAY 8	WEDNESDAY 9	THURSDAY 10	FRIDAY 11
9:00 - 9:30	Greetings Tour	Small Group →	→	→	→
9:30 - 10:20	Awareness/ Art Therapy	Karate/ Music	Music/ Art Therapy	Awareness/ Karate	Awareness/ Arts & Crafts
10:20 - 10:40	SNACK →	→	→	→	→
10:4 - 11:30	Awareness/ Art Therapy	Karate/ Music	Music/ Art Therapy	Awareness/ Karate	Awareness/ Arts & Crafts
11:30 - 12:30	LUNCH →	→	→	→	→
12:30 - 1:00	Orienteering	Cooking/ Sport	Big Group	Arts & Crafts Sport	Trip to Southland ↓
1:00 - 1:30	Orienteering	Cooking/ Sport	Sport	Arts and Crafts/ Sports	↓
1:30 - 2:00	Swimming ↓	Swimming ↓	Cooking/ Orienteering	Mad Science ↓	↓
2:00 - 2:15	↓	↓	Snack/ Orienteering	↓	↓
2:15 - 2:45	↓	↓	Cooking/ Orienteering	↓	↓
2:45 - 3:00	SNACK →	→	→	→	→
3:00 - 3:30	Return		Small Group	Small Group	Return
3:30 - 4:30	Counsellor planning and supervision	→	→	→	→

Calgary Learning Centre
June 23, 1997
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CAMP SCHEDULE: WEEK 2

TIME	MONDAY 14	TUESDAY 15	WEDNESDAY 16	THURSDAY 17	FRIDAY 18
9:00 - 9:30	SMALL GROUP	→	→	→	Tim Hortons
9:30 - 10:20	Awareness/ Art Therapy	Music/ Art Therapy	Karate/ Music	Awareness/ Karate	
10:20 - 10:40	SNACK TIME →				→
10:40 - 11:30	Awareness/ Art Therapy	Music/ Art Therapy	Karate/ Music	Awareness/ Karate	
11:30 - 12:30	LUNCH →	→	Lake Sikome	Arts & Crafts/ Cooking	
12:30 - 1:00	Sport →	→		~~Swimming~~ Art./Cafe	
1:00 - 1:30	Energium	Awareness/ Sport		Cooking	
1:30 - 2:00		Awareness/ Sport		Swimming	
2:00 - 2:15		Orienteering			
2:15 - 2:45		Orienteering			
2:45 - 3:00		Orienteering			
3:00 - 3:30	Small Group →	→			
3:30 - 4:30					

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June 23, 1997
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CAMP SCHEDULE: WEEK 3

TIME	MONDAY 21	TUESDAY 22	WEDNESDAY 23	THURSDAY 24	FRIDAY 25
9:00 - 9:30	SMALL GROUP				Planning
9:30 - 10:20	Art Therapy/ Awareness	Karate/ Music	Art Therapy/ Awarness	Awareness/ Karate	Small Groups
10:20 - 10:40	SNACK				
10:40 - 11:30	Art Therapy/ Awareness	Karate/ Music	Art Therapy/ Awarness	Awareness/ Karate	Small Groups
11:30 - 12:30	LUNCH				
12:30 - 1:00		Awareness/ Cooking	Orienteering	Cooking/ Music	
1:00 - 1:30	Science Centre	Awareness/ Cooking		Cooking/ Music	Family Afternoon
1:30 - 2:00		Swimming	Canoeing	Swimming	
2:00 - 2:15					
2:15 - 2:45					
2:45 - 3:00					
3:00 - 3:30					
3:30 - 4:30					

Calgary Learning Centre
June 23, 1997
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APPENDIX 4: Camp ADDventure brochure

The Calgary Learning Centre

The Calgary Society for Students with Learning Difficulties operates the Calgary Learning Centre. It opened in December 1979 with the primary goal of improving services for people with learning difficulties through research, professional outreach and client services.

PATRONS:

Imperial Oil

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NOVA

AMOCO

Shell

The Calgary Learning Centre
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Calgary, Alberta T2T 4Z9
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CALGARY SOCIETY FOR STUDENTS WITH LEARNING DIFFICULTIES

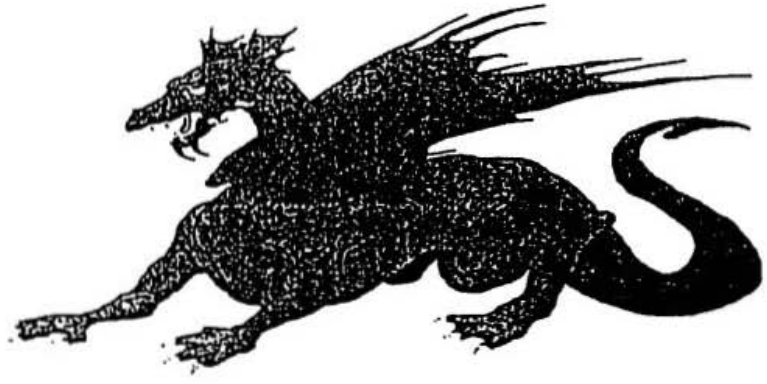
PARTICIPATING MEMBERS:

Alberta Children's Hospital, Alberta Vocational College - Calgary, Calgary Board of Education, Calgary Catholic Board of Education, Calgary Health Services, Kinsmen Club of Calgary, Learning Disabilities Association of Alberta - Calgary Chapter, University of Calgary.

THE CALGARY LEARNING CENTRE

1997 CAMP ADD-VENTURE

For Children with Attention Deficit/ Hyperactivity Disorder



Who is eligible?

- Children between the ages of 8 and 11 who have Attention Deficit/ Hyperactivity Disorder

When?

- The Camp will run Monday to Friday, July 7 - 25, 1997 from 9:00 a.m. - 3:30 p.m. daily.

How?

- Call Gill Hutton or Simone Shindler at 686-9300 for more information.

SPONSORED BY: TransCanada

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Children with Attention Deficit/Hyperactivity Disorder (AD/HD) often encounter difficulties during the school summer holiday. Some of these children can benefit from involvement in a structured program where they can have fun, and can also learn coping skills that will benefit them socially, emotionally and academically. For the past five summers the Calgary Learning Centre has offered a summer camp program specifically for AD/HD children. Our camp stresses the positives in the children, allows them to explore their feelings and to work towards their potentials.

During the 3 week program, campers will:

- be taught strategies to reduce impulsivity and increase self control
- practice problem-solving
- practice appropriate social skills
- be taught strategies that may be helpful in the classroom
- increase their awareness about AD/HD

while participating in fun recreational activities such as swimming, arts/crafts, games, sport, cooking and field trips.

Registration Information

NUMBER OF CAMPERS: 18

STAFF:

Three members of Calgary Learning Centre's professional staff are involved in running the camp. The camp staff also includes six counsellors, all with backgrounds in education, social work, psychology or related fields.

REGISTRATION:

For more information about the camp and to arrange a screening interview, please contact Gill Hutton or Simone Shindler at 686-9300.

CAMP FEE:

$800.00 **PER CAMPER** - The Calgary Learning Centre is pleased to announce that through generous community donations, bursary funds are available.

BURSARIES:

For information on our bursary program, please review the enclosed information or call Carolyn Meier - 686-9300.

A pre-camp information evening will be provided for campers and parents.

Comments from previous campers .....

Kids

What did you like about camp?

"Everything (the very funnest ever)"

What did you learn about AD/HD?

"It doesn't mean you're bad.
There are lots of good things about it"

Parent

What do you think your child has learned about having AD/HD as a result of this program? Has it been helpful?

" YES! The professional staff and counsellors at the centre provided an excellent opportunity for the children to understand the hows & whys of ADD, the medications involved, how to accept the condition and how to ask questions about ADD without feeling uncomfortable."

APPENDIX 5: Counselor Individual Profiles

INDIVIDUAL PROFILES

COUNSELORS

Counselor "A"

Counselor "A" was a 23-year-old female completing a Master of Teaching degree at the University of Calgary. She has a Bachelor of Arts degree with a major in psychology.

Counselor "B"

Counselor "B" was a 26-year-old male completing a Master of Teaching degree at the University of Calgary. He had a Bachelor of Arts degree with a major in history.

Counselor "C"

Counselor "C" was a 31-year-old female completing a Master of Teaching program at the University of Calgary. She had a Bachelor of Arts degree with a major in humanities.

Counselor "D"

Counselor "D" was a 24-year-old male who had a Bachelor of Science degree in kinesiology with a minor in psychology from the University of Calgary.

Counsellor "E"

Counsellor "E" was a 26-year-old female who had a Bachelor of Education degree from the University of Calgary and was working as a substitute teacher.

Counselor "F"

Counselor "F" was a 24-year-old female completing a Bachelor of Education degree at the University of Calgary. Her major is in special education and her minor is in social studies.

APPENDIX 6: Example of Camp ADDventure final report

ADD SUMMER CAMP
FINAL REPORT

NAME:
DOB: May 18th, 1980 DATE OF REPORT: August 6th, 1992

BACKGROUND INFORMATION:

X was referred to the camp program by her parents, X lives at home and attends grade 6 at Big Rock Elementary. She is part of a modified education program called 'Challenge'. X was diagnosed with Attention Deficit Hyperactivity Disorder during her grade one year by Dr. Moghadam. X is presently taking ritalin and appears to be a positive responder.

REASON FOR REFERRAL:

X is described by her parents as being a child who appears to stand apart from other children in her home community. This seems to primarily be due to some of her extraneous body movements such as the flicking of her hands, rocking back and forth, as well as seemingly uncontrolled leg and arm movements. X reportedly has difficulty concentrating and has poor social skills which include a lack of awareness of other people in her environment.

BEHAVIORAL OBSERVATIONS WHILE AT CAMP:

X's counsellors report that X got along well with other children at the camp and they in turn responded well to her. X in fact appeared to be the 'glue' that held her group of three girls and two boys together. She was easily able to interact both within this small group and within the group as a whole which included 15 children. Though physically bigger and older than the other children, this did not appear to hinder her interactions. X generally displayed good humor and was always ready to participate and have fun.

Counsellors also observed that X at times appeared to have difficulty remembering and respecting others 'personal space'. This would find her sometimes touching others inappropriately or standing/sitting too close to others. X is an affectionate person who however must be reminded that their are boundaries between people that need to be observed. When this was brought to her attention, she was able to generally keep her behavior in check. By the end of the program this generally ceased to be a problem.

There was some concern over X's quest to gain knowledge in regard to AIDS and reproduction. This, along with the observed experimentation of makeup that X undertook during the program, is probably somewhat normal for her age. Problematic however, was her method of inquiry, eg. asking direct questions of people that were inappropriate and poorly timed. This is no doubt also related to her observed impulsivity. Though counsellors attempted to work with X on this issue, the hoped for progress in this area was not observed to the extent hoped for.

X worked hard at curbing her impulsivity, eg. interrupting. At times she appeared to become over stimulated which would result in observed body movements such as hand and arm flapping, rubbing. These behaviors appeared to lessen while on ritalin. X was often observed to go off by herself at which times she seemed to be fantasizing, talking to herself. She often seemed to make up stories, eg. about boyfriends. Though some stories were known to be embellished upon, X was seen to stick by her own understanding of situations. Though her stories where not an issue between herself and the other children at camp, this could be an area of contention in her home community as could her tendency to talk to herself and odd mannerisms.

X is described by her counsellors as being a very a caring person. She is friendly and outgoing, always willing to lend a hand. X possesses a vast amount of general knowledge which was displayed on a daily basis but especially when we visited the zoo and the sheep farm. She was able to share this knowledge in a manner that held the interests of others and that was appreciated. X's sense of humor was always enjoyed at the camp.

NEEDS:

X appeared to benefit immensely from the program. She increased her use of many social skills, made friends and found acceptance. This should have had a positive impact on her self esteem. X may benefit from continued exposure to this type of programming where she can work on further on her social skills and her general ability to interact successfully with others. X's tendency to retreat into fantasies and her uncontrolled body movements may require further professional attention.

We wish X the best of luck in the future, she was a wonderful charismatic addition to our program.

Simone Shindler M.A., M.S.W Sandy Mann M.Ed.

APPENDIX 7: Individual Profiles of Campers

INDIVIDUAL PROFILES

CAMPERS

Camper "A"

Camper "A" was an 8-year-old girl. Family consisted of mother, father, a thirteen-year- old older brother and a 3-year-old younger sister. Her father is self-employed and her mother is a homemaker. Alberta Mental Health was the referral source. She is on Ritalin (10 mg.) once per day, six days a week. Her parents rated her social interactions as a minor problem.

Camper "B"

Camper "B" was a 9-year-old boy. Family consisted of mother, father, and a 5-year-old younger sister. Father is an accountant, mother is a counsellor. Mom found out about the camp on her own and referred her son. He is on Dexedrine Slow Release (40 mg) daily. His parents rated his social interactions a minor problem.

Camper "C"

Camper "C" was a 10-year-old boy. Family consisted of mother, father, a twin sister and an older brother, 12-years-old. Father was presently unemployed and mother was a college student. Mom referred her son. He was on Methylphenidate (10 mg) during school but is off medication for the summer and during camp. His parents rated his social interactions a minor problem.

Camper "D"

Camper "D" was a 10-year-old boy. Family consisted of mother and a 7-year-old younger brother. Mother is a nurse. Social Services was the referral source. He is on Dexedrine
(15 mg) daily. His mom rated his social interactions as a minor problem.

Camper "E"

Camper "E" was a 7-year-old boy. Family consisted of mother, father, and a 3-year-old sister. Father is a tax assessor, mother works at home. Mother referred her son. He is on Ritalin (10mg) two to three times per day. Parents rated his social interactions a minor problem.

Camper "F"

Camper "F" was a 10-year-old boy. Family consisted of mother, father, a 10-year-old step-brother and a 7-year-old half-brother. Father works for the City of Calgary and mother is an administrative assistant. A friend daughter attended the camp the previous year and referred the camp to them. He is on Ritalin slow release (20 mg) daily. Parents rated his social interactions as a minor problem.

Camper "G"

Camper "G" was a 8-year-old boy. His family consisted of mother, father, a 10-year-old older brother, and a 6-year-old younger brother. Father is a salesman and mother is a homemaker. The parents referred him. He is on Ritalin (15 mg), with 10 mg given in the morning and 5 mg given at 4:00 p.m. His parents rated his social interactions a minor problem.

Camper "H"

Camper "H" was a 8-year-old girl. Her family consisted of mother, father, a 6-year-old younger brother, and a 4-year-old younger sister. Both mother and father work in Accounting. Her parents were the referral source. she is on Ritalin (10 mg) twice a day. Her parents rated her social interactions a severe problem.

Camper "I"

Camper "I" was a 9-year-old boy. His family consisted of mother and father. Father is a transport driver and mother is a nurse. A physician was the referral source. He is on Dexedrine span (15 mg) and Dexedrine TB (5 mg) taken once every morning. His parents rated his social interactions a severe problem.

Camper "J"

Camper "J" was a 9-year-old boy. Family consisted of mother, father, and two younger brothers (7- and 4-years-old). Father is a consultant. Mother and father are the referral source. He is on Ritalin 1 1/2 tablets twice daily (morning and noon). His parents rated his social interactions as a severe problem.

Camper "K"

Camper "K" was a 9-year-old boy. Family consisted of mother and father. Occupations unspecified. Referral source unspecified. He is on Ritalin 1/2 tablet 2-3 times a day (approx. every four hours). Social interactions were not rated.

Camper "L"

Camper "L" was a 9 1/2 year-old girl. Her family consisted of mother and father. Father is unemployed and mother is a school bus driver. A friend was the referral source. She is on Ritalin one tablet daily at lunchtime. Social interactions rated by parents rated as a minor problem.

Camper "M"

Camper "M" was a 10-year-old girl. Family consisted of mother, father, and 7-year-old younger sister. Father works with Computers and mother is an artist. A teacher was the referral source. She not currently on medication. Social interactions rated by parents as a minor problem.

Camper "N"

Camper "N" was a 8-year-old girl. Family consisted of mother, father, and a 10-year-old older brother. Father is a Stone Mason Apprentice and mother works as a child care aide. Mother and Father were the referral source. She is on Dexedrine (15 mg) in morning and 5 mg in evening. Parents rated social interactions a severe problem.

Camper "O"

Camper "O" was a 8-year-old boy. Family consisted of mother and her boyfriend. Occupational, referral, medication and social interaction information was not available.

Camper "P"

Camper "P" was a 11-year-old boy. Family consisted of mother, father, and a 16-year-old sister. Father is a truck driver and mother is an executive secretary. Parents were referral source. He is on Dexedrine (dosage not specified). Social interactions rated by parents as a minor problem.

Camper "Q"

Camper "Q" was a 8-year-old boy. Family consisted of mother, father, and 9-year-old sister. Father is a factory worker and mother is a systems analyst. Parents were referral source. He is on Dexedrine 1 1/2 tablets (1 in A.M., 1/2 at noon). Social interactions not a problem.

Camper "R"

Camper "R" was a 9-year-old girl. Family consisted of mother, father, and 2 1/2-year-old sister. Mother is a homemaker, father is unemployed. School was the referral source. She is on Ritalin (dosage unspecified). Social interactions were rated by parents as a minor problem.

Camper "S"

Camper "S" was a 10-year-old boy. Family consisted of father, mother, 7-year-old sister, and 6-year-old brother. Father is a law student and mother is a nurse. Parents were referral source. He is on Ritalin 15 mg twice a day (a.m. and noon) on school days only. Social interactions rated by parents as a minor problem.

APPENDIX 8: Consent form

THE CALGARY LEARNING CENTRE

CONSENT FORM
CAMP ADDventure RESEARCH

As a graduate student completing an internship at the Calgary Learning Centre I am required to complete a research component. I have chosen to study the effectiveness of cognitive strategies used by counsellors at Camp ADDventure in enhancing appropriate social behaviours and increasing the self-monitoring of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) attending the camp in July 1997. In addition to fulfilling my research requirements, this information will help the Calgary Learning Centre to monitor the benefits of the camp and improve on the quality of this service.

In this study I will be gathering information from the following sources: behavioural observations, field notes, camp screenings, counsellor's notes, and camp evaluations. You may also be contacted at some time after the completion of the camp and asked about your impressions of the camp.

All information gathered will be strictly confidential; no identifying information such as proper names will ever be published and all information gathered will be kept in a locked filing cabinet on the Calgary Learning Centre premises. You may choose not to participate in this study at any time and that decision would not interfere with any services received at the Calgary Learning Centre. If you have any questions regarding this research you may contact the leaders of the camp, Shawn Crawford and/or Gill Hutton at the address or phone number below. I appreciate your cooperation in this matter.

Tina R. Parsons, M.Sc
Internship Student

3930 - 20th Street S.W., Calgary, Alberta T2T 4Z9 Phone (403) 686-9300 Fax (403) 686-0627 E-Mail calearnc@cadvision.com

I _____consent to allow my son/daughter_____

to be observed as part of a research project conducted by Tina Parsons as part of an internship requirement.

I acknowledge that:

1. I have been informed of the nature of this research.

2. I understand that my child's full name will never be published as part of the research.

3. I have been informed that all information gathered is strictly confidential and for research purposes only.

4. I understand that the decision not to participate can be made at any time and will not interfere with any services received at the Calgary Learning Centre.

_____ _____

PARENT/GUARDIAN WITNESS

_____

DATE

PLEASE COMPLETE AND RETURN THIS PORTION, KEEP THE OTHER COPY FOR YOUR RECORDS.

I_____ consent to allow my son/daughter _____

to be observed as part of a research project conducted by Tina Parsons as part of an internship requirement.

I acknowledge that:

1. I have been informed of the nature of this research.
2. I understand that my child's full name will never be published as part of the research.
3. I have been informed that all information gathered is strictly confidential and for research purposes only.
4. I understand that the decision not to participate can be made at any time and will not interfere with any services received at the Calgary Learning Centre.

_____ _____

PARENT/GUARDIAN WITNESS

_____

DATE

APPENDIX 9: Art therapy description

ART THERAPY

WHAT IS ART THERAPY?

Art therapy is a therapeutic modality based on certain principles drawn from the fields of psychology and the visual arts. Art therapy proposes a creative, imaginative and visually oriented experience, and comprises non-verbal and symbolic self-expression. The art therapy process unfolds in the context of a therapeutic relationship, in which the creation of images is the primary mode of communication. Artistic activity gives concrete expression to both conscious and unconscious elements, and is in itself a therapeutic agent. Through various art processes (drawing, collage, painting, or sculpture) art therapy clients may experience and express emotions, conflicts, or memories. During an art therapy session, clients often verbally explore the symbolism and meaning of their imagery with the art therapist.

WHY CONSULT AN ART THERAPIST?

Art therapy is intended as much for individuals (children and adults), as it is for couples, families, and groups. Art therapy responds to individuals interested in improving their psychological well-being through the creation of images within a therapeutic context. Emotional equilibrium, enhanced interpersonal relationships, and enriched self-awareness may be among the therapeutic objectives of individuals in art therapy. This approach can provide a gentle invitation to introspection, or facilitate awareness and understanding of one's problems and conflicts.

WHAT IS THE ROLE OF THE ART THERAPIST?

Art therapists accompany their clients in the therapeutic encounter. They facilitate creative work, may comment, and at times, interpret the verbal or visual reflections of the individual. Art therapists conduct an assessment and plan a therapeutic approach based on the client's needs. When appropriate, art therapists work in conjunction with other professionals (psychiatrists, psychologists, teachers, and social workers) or with the family, and may propose treatment plans. An art therapist may be consulted for either long-term or for short-term therapy.

Source: Quebec Art Therapy Association, 1994.

APPENDIX 10: Anecdotal Informal Notes on Campers

INDIVIDUAL PROFILES

SAMPLE OF COUNSELORS INFORMAL NOTES ON CAMPERS ON TARGET DAYS 3, 8, AND 15

Notes on Camper "A":

-Displayed a keen interest in crafts.

-Always participates with enthusiasm and has extremely unique ideas.

-Provokes boys in group by chasing them or attempting to kiss them.

Notes on Camper "B":

-Sometimes reluctant to share in group discussions.

-Becomes very quiet when required to speak in front of other people.

-Fascinated by war and military issues.

Notes on Camper "C":

-Raises hand before speaking and is very co-operative in volleyball.

-Quiet in group discussions.

-Has potential to monopolize group discussions.

Notes on Camper "D":

-Very interested in self-directed activities like puzzles.

-Praises other but only in a way that maintains his image of being "cool".

-Needs to ask and not demand things.

Notes on Camper "E":

-Needs constant reinforcement to stay on task.

-Seems fixated on anything to do with motor boats.

-Claimed that there was on a sign on his brain that says "I have ADD."

Notes on Camper "F":

-Responds well to time limits.

-Able to express emotions of frustration.

-Very respectful of adults and follows directions.

Notes on Camper "G":

-Participates eagerly in all activities.

-Encourages and praises other work.

-Well behaved; displayed helping behaviours.

Notes on Camper "H":

-Calls her medication a "stupid pill".

-Uses her words to express herself.

-Socially able to make and keep friends.

Notes on Camper "I":

-Likes to talk. Seems to be able to talk as long as someone will listen.

-Very focused during art and crafts.

-Not able to express feelings in a positive way.

Notes on Camper "J":

-Interactions with other campers positive.

-Eager and willing to praise others.

-Does own exploring as opposed to following others.

Notes on Camper "K":

-Remarkably quiet and composed in awareness class.

-Enjoyed making and decorating a mask.

-Problem with rule of keeping hands, feet and objects to self.

Notes on Camper "L":

-Lack of independence.

-Sometimes hits others in frustration.

-Very attentive during movie on AD/HD awareness.

Notes on Camper "M":

-Needs to take control of her own happiness in activity situations

-Very polite when she asks for things.

-Very pleasant to be with overall.

Notes on Camper "N":

-Became open and shared her feelings of isolation and rejection at school during awareness class.

-Could practice sharing with others.

-Told a counselor that she often reads to "avoid the pain of not having friends."

Notes on Camper "O":

-Can be "quick with his tongue."

-Has leadership qualities in volleyball.

-Needs help with anger management.

Notes on Camper "P":

-Has good and bad moments.

-Lets his sense of humour show.

-Some anger control difficulties.

Notes on Camper "Q":

-Tends to be independent.

-Needs to decrease blaming and giving insults to others.

-Very talkative, outgoing and enthusiastic.

Notes on Camper "R":

-Refuses to sing in music.

-Tendency to stick with counselors.

-Very focused in art therapy.

Notes on Camper "S":

-Very enthusiastic about karate and music.

-Praises other people's work.

-Uses humour to get his point across.

APPENDIX 11: Informal Excerpts of Narration by Campers

Examples of excerpts of narration taken from campers and counsellors on selected days.

As one boy runs over an ant with a toy truck, another boy responds: "That's not nice, you wouldn't like it if someone ran over you like that!"

Boy diagnosed with AD/HD says to his Mom on first day of camp: "I don't know about this camp, the other kids are way too hyper!"

"Hit the dirt!" Statement made by boy as rocket they launched during "Mad Science" takes off.

"I just goes to the bathroom and waits." Boy's description of how he manages anger.

"We warned them we were coming!" Counsellors description of what they said to personnel at Southlands Leisure Centre before 19 AD/HD kids arrived to swim there.

"Can't we just stand NEXT to the edge of the water?" Boy displaying self-control as he waits for others to finish lunch so they can swim in Lake Sikome.

"Oh her, she's the lady who collects research...you know, she's a researcher!" Overheard as stated by two campers on the bus ride to Tim Horton's camp (so much for anonymity!).

"I'm choosing to ignore you!" Response made by a boy who was being teased by another boy.

"It's a good thing you picked the topic of anger for today 'cause we need lots of help with that!" Statement made by a boy to the art therapist.

"AD/HD comes from your genes...not like denim jeans, but genes from your mom and dad. My AD/HD comes from my dad." Answer given by a girl during an awareness class.

"Do animals get AD/HD? I have a really hyper dog." Question asked by a girl in awareness class.

"I feel bad that camp is ending..." Statement made by a boy during the last art therapy class.

APPENDIX 12: Data Table of Number of Socially-Appropriate and Self-Corrective Behaviours Displayed by Campers over 8 Target Days

Data Table: Number of socially-appropriate and self-corrective behaviours displayed by campers over 8 target days.

Target Behaviours:

SA = Socially-Appropriate

SC = Self-Corrective

	DAY1	DAY2	DAY3	DAY4	DAY5	DAY6	DAY7	DAY8
	SA:SC (combined across all observers)							
Camper A	5:0	4:0	4:0	3:0	9:0	2:0	4:0	3:0
Camper B	5:0	2:0	4:0	5:0	4:0	1:0	5:0	2:0
Camper C	6:0	10:0	1:0	10:1	6:0	2:0	3:0	4:0
Camper D	6:0	9:0	0:0	0:0	3:0	2:0	0:0	1:0
Camper E	5:0	2:0	3:0	6:0	6:0	6:0	2:0	4:0
Camper F	6:0	8:0	14:0	13:0	5:0	7:0	8:0	4:0
Camper G	12:0	3:0	4:0	9:0	8:0	1:0	7:0	1:0
Camper H	3:0	5:0	4:0	5:0	3:0	3:0	6:0	5:0
Camper I	7:0	5:0	3:0	8:3	3:0	8:1	4:0	3:0
Camper J	5:0	1:0	4:0	7:0	4:0	4:0	6:0	4:0
Camper K	2:0	0:0	3:0	5:0	2:0	11:3	3:0	4:0
Camper L	8:0	2:0	4:0	7:0	3:0	7:0	8:2	3:0
Camper M	6:0	5:0	5:0	6:0	7:0	3:0	6:0	3:0

Camper N	0:0	2:0	5:0	0:0	5:0	5:0	2:0	0:0
Camper O	6:0	2:0	5:0	6:0	7:0	3:0	8:0	0:0
Camper P	0:0	3:0	0:0	0:0	9:0	2:0	6:0	7:0
Camper Q	5:0	1:0	2:0	2:1	0:0	6:0	7:0	4:0
Camper R	5:0	4:0	7:0	3:0	4:0	3:0	5:0	4:0
Camper S	0:0	5:0	29:0	5:0	5:0	11:1	7:0	9:0

	Week1 (Days 1-2)	Week2 (Days 3-5)	Week3 (Days 6-8)
Totals (SA)	148	294	249
Means (SA)	3.9	5.1	4.3
Totals (SC)	12	10	12
Means (SC)	0.3	0.1	0.2