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Using Video Modeling to Improve Staff Implementation of the PEAK Relational Training System

Kelsie Thompson

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Using Video Modeling to Improve Staff Implementation of the PEAK Relational Training System

by

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts
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Date of Approval:
November 1, 2018

Keywords: PEAK, relational frame theory, video modeling, staff training

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DEDICATION

This manuscript is dedicated to my wonderful and supportive family for encouraging me to challenge myself and achieve my goals. My gratitude also goes to my boyfriend Chris, who has been incredibly supportive of my efforts, and whose positive outlook has always inspired me. I am also grateful for my supervisors, coworkers, and clients at BCOTB, who made conducting this thesis a pleasure.
ACKNOWLEDGMENTS

Much thanks for my advisor Dr. Kimberly Crosland for your insight and commitment to this project. Thank you to Dr. Raymond Miltenberger and Dr. Catia Cividini-Motta for serving on my committee and providing valuable feedback. Additional thanks to Behavioral Consulting of Tampa Bay for allowing me to work with your employees and conduct this study at your locations.
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ABSTRACT

Evidence suggests that the Promoting the Emergence of Advanced Knowledge Relational Training System (PEAK) is an effective method of providing verbal behavior training to individuals with developmental disabilities, and previous research indicates that BST can be used to train staff in its implementation. Video modeling is a modification to BST that can decrease the amount of resources necessary to provide instruction without limiting the effectiveness of the training. This study evaluated the effectiveness of using video modeling for teaching direct care staff how to implement the Promoting the Emergence of Advanced Knowledge Relational Training System (PEAK) using a multiple baseline across participants design. All participants showed improvement in PEAK implementation with video modeling treatment; one required the addition of a checklist to achieve mastery. Implications for further research are discussed.
CHAPTER ONE:
INTRODUCTION

Verbal behavior programming has been consistently implemented as a treatment for autism spectrum disorders, and, as a result, various manualized interventions have emerged (Reed & Luiselli, 2016). One such curriculum is the Promoting the Emergence of Advanced Knowledge Relational Training System (PEAK; Dixon, 2014). PEAK is founded on principles of relational frame theory (Hayes, 1994), and is specifically designed to promote the generalization of learned skills, which is significant as children with developmental disorders appear to develop generalization differently than their peers (Dixon et al., 2017). Additionally, PEAK training places a focus on teaching stimulus equivalence, which improves an individual’s ability to derive relationships between novel stimuli (McKeel & Matas, 2017).

The efficacy of PEAK has been examined in a variety of research studies. McKeel, Dixon, Daar, Rowsey and Szekely (2015) compared a group of students who received standard classroom teaching to a group who were exposed to brief PEAK training sessions twice a week. Those in the experimental group demonstrated improved skills in the targeted areas, providing evidence that even minimal exposure to PEAK training can be effective. PEAK has been shown to correlate with other common language assessments (Malkin, Dixon, Speelman, & Luke, 2016), and scores on the PEAK assessment also correlate with IQ scores (Dixon, Whiting, Rowsely, & Belisle, 2014).

For clients to reap the full benefits of the PEAK curriculum, those implementing PEAK procedures must be properly trained in the material. The body of empirical research regarding
the best methods for staff training and management is growing continuously, and employers are
constantly seeking ways to train employees efficiently and effectively (Richards, 2012; Quiñones, 1997). Employees who work directly with individuals in need of specialized care
require extensive training as treatment fidelity is extremely important. High levels of
intervention implementation often begin with good training and staff adherence (DiGennaro,
Martens, & McIntyre, 2005). In addition, effective training and management contributes to the
overall satisfaction of employees, employers, and those who receive direct care services
(Goldhaber-Fiebert, Lei, Nandagopal, & Bereknyei, 2015; Spector, Revolta, & Orrell, 2016;
Vladescu, Carroll, Paden, & Kodak, 2012).

Training employees can be a costly endeavor (Richards, 2012), and continual training of
employees who do not perform well only increases that cost. Therefore, research in the field of
effective employee training and skill maintenance is highly valuable. Many studies have
evaluated different methods of staff training and how they can be applied (Fleming, Oliver, &
Bolton, 1996; Hatlenes & Eikeseth, 2016; Schepis, Reid, Ownbey, & Parsons, 2001; Sulzer-
Azaroff & Fox, 1990).

Much of the current literature supports the use of behavioral skills training (BST) to
educate new employees. BST, which includes description of necessary skills, modeling,
rehearsal, and feedback (Miltenberger et al., 2004), has been very effective in teaching a variety
of social and safety skills to typically-developing individuals as well as those with
developmental disorders (Lovejoy & Heckman, 2014; Nuernberger, Ringdahl, Vargo,
Crumpecker, & Gunnarsson, 2013). Research also suggests BST can also be used to efficiently
train staff (Belisle, Rowsey, & Dixon, 2016; Corrigan et al., 1995; Fleming et al., 1996; Hine,
BST has been found to be more effective than informational training alone. Whiting, Miller, Hensel, Dixon, and Szekely (2014) compared training methods for teaching school staff to administer an EpiPen in an emergency. One group of staff members were trained by an instructional video, while the other received instruction, modeling, rehearsal, and feedback. The BST group performed the targeted task more successfully than those in the control group. Additionally, Fleming et al. (1996) demonstrated that BST can be used to teach supervising staff how to train lower-level employees, providing businesses with the option of a “pyramidal” training model.

An invaluable option when using BST is the opportunity for employees to be trained in actual work-related situations. In situ training allows staff to confront issues and concerns they may face in their regular work day, and improves employee responses in those real-time situations (Theilen, Fraser, Jones, Leonard, & Simpson, 2013). In situ training has been found to be more effective than self-directed training alone (Hatlenes & Eikeseth, 2016).

BST with in situ training can benefit not only the recipients of the training, but also the recipients of the service provided. Schepis et al. (2001) focused on teaching staff working with children with developmental disabilities in a preschool setting. Staff were provided classroom-style training on how to engage learners in teaching opportunities during their regular routines and activities, as well as on effective prompting procedures, error correction, and implementation of reinforcement. This was followed by on-the-job training, with additional training and feedback provided by the senior school staff. All staff demonstrated higher percentages of
correctly implemented teaching opportunities, and students demonstrated higher levels of independent responding following training.

In situ training may also provide a valuable dimension of social validity to staff training. Goldhaber-Fiebert et al. (2015) found that medical professionals who paired reading emergency procedure manuals with in situ training felt more comfortable with emergency procedures, and they were also more likely to refer to the manuals after training. This indicates that in situ training is not only effective in disseminating information, but also increases employee confidence and familiarity with training material.

In-situ BST has been shown to be effective specifically in training employees to implement PEAK. Belisle et al. (2016) used BST to train direct care staff in implementing a language training program with individuals with autism. Staff were provided with reading material on the program before baseline data was taken. They were then trained using BST including instruction, modeling, and in situ rehearsal with a client. Staff were provided with feedback following implementation with the clients. Implementation fidelity improved to 100% for all participants, and the skills were maintained in maintenance probes.

While BST is an effective way to train staff, there are a couple of limitations. The full process of description, modeling, rehearsal, and feedback can be time consuming (Parsons et al., 2012) and ensuring every employee reaps all the benefits of BST is difficult (Whiting et al., 2014). The feasibility of using BST for extensive retraining is limited, and BST can be a major drain on company resources.

To make using BST more accessible, modifications to the traditional BST approach can be successful. One such modification is using video modeling. This allows the modeling portion of BST to be prepared prior to training and used for multiple employees rather than staging
individual modeling situations. Vladescu et al. (2012) used video modeling paired with voiceover instruction to teach new employees at a clinic for children with developmental disabilities discrete-trial teaching procedures. Trainees were assessed according to their ability to follow a receptive identification protocol with a confederate before and after viewing two video examples with instructive voiceover. They were then assessed according to their accuracy with a child participant and across novel teaching tasks. Results indicated video modeling was effective in increasing trainee’s ability to demonstrate the skill. Similar results for video modeling were demonstrated by Loughrey, Marshall, Bellizzi, and Wilder (2013), providing further evidence that traditional BST can be effectively modified to better suit employer needs and goals.

Utilizing video modeling is an affordable and efficient way to modify BST training sessions to better suit employee needs. This may be particularly effective for companies looking to train employees on manualized programs like the PEAK relational training system. Therefore, the purpose of this study was to evaluate the effectiveness of video modeling on staff implementation of the PEAK- DT curriculum.
CHAPTER TWO:

METHOD

Participants and Setting

Participants included three newly hired staff members at a behavioral analysis company specializing in verbal behavior training. Participants had varying experience in behavior analysis, but no experience with the PEAK curriculum. All participants were between the ages of 21 and 24. Marilyn (names have been changed) had work experience in teaching verbal behavior programming, while Lucy and Ana had no experience in the field. Participation in the research was optional for all trainees, and they were provided the option to participate before beginning new employee training. They were informed of the purpose of the research via a consent form and a meeting with the researcher, where they could ask any questions.

All sessions took place within the clinic during the employee’s onboarding training. During informational training sessions, participants were seated in a room either alone or with multiple other trainees, with a private computer. Implementation sessions were held in a private therapy room with a table, chairs, stimuli necessary for PEAK programming, and a binder containing the PEAK materials, including program sheets and data sheets. Data from the study were not made available to the participant’s employers and/or supervising staff to protect participant confidentiality and job security.
Materials

**PEAK materials.** Participants were provided with binders containing PEAK programming material for each session. Binders included program instruction sheets, which described the goal of the program, the teaching protocol, and the list of necessary stimuli (see Appendix A). Binders also included a direct training data sheet, where participants collected data for the session (see Appendix B). Necessary stimuli (matching items) were also provided for the program. Additionally, confederates were provided with an instruction sheet including a randomly assigned sequence of responses (four correct responses, four incorrect responses, and two no responses (no meaningful movement or attempt to respond) for each session.

**Informational slideshow.** An informational slideshow with voiceover instruction was used during the baseline phase. This informational training was part of the participant’s general staff training. The slideshow was three minutes and 45 seconds long, and included information about PEAK programming, including understanding program instruction sheets, preparing for a PEAK session, implementing PEAK prompting procedures, and collecting data using the direct training data sheet.

**Video model.** A video model was used during the treatment phase. This video was created by the researcher and supervising staff, and included voiceover commentary that provided an explanation for the modeled teaching components. The video was three minutes and 41 seconds long, and modeled preparing for a PEAK session, implementing PEAK prompting procedures, and collecting data using the direct training data sheet.

**Target Behavior and Data Collection**

The dependent variable was the percent correct implementation of PEAK programming. Percent correct implementation was measured using a modified version of the PEAK
Implementation Checklist (PEAK-IC) developed by Belisle et al. (2016) (Appendix C). The checklist was modified to better match the expectations of the company. Items that were not consistent with the competencies used to measure mastery by the company were not included. Other items were modified according to the company’s expectations. For instance, “allows 3 seconds to respond” was changed to “allows 5 seconds to respond”. Each training session was made up of a 10-trial block, and the observer scored up to 10 task items for each trial. Items were scored as correct, incorrect, or non-applicable (for instance, if a correct response was given on the initial attempt, the use of a correct prompt was not applicable for that trial). The total number of steps scored as correct were divided by the number of total scored items for the trial block, multiplied by 100%, to yield a percent of correct implementation.

**Interobserver Agreement (IOA)**

All sessions were video recorded, and the researcher collected data for each session via the recordings. Data were collected using the PEAK Implementation Checklist (Appendix C), and all applicable items were scored. Items were scored according to the scoring guide (Appendix D).

IOA was calculated for 40% of sessions for Lucy, 57% of sessions for Ana, and 40% of sessions for Marilyn. The researcher met with the research assistant to develop the scoring guide for items on the checklist. They then scored two videos together to 95% IOA. The research assistant then watched videos of the sessions and scored percent correct implementation using the same PEAK Implementation Checklist as the researcher. An agreement occurred if both data collectors marked an item “correct”, both marked an item “incorrect”, or both marked an item “non-applicable”. A disagreement occurred if one data collector marked an item “correct”, “incorrect”, or “non-applicable” while the other data collector marked that item differently. IOA
was calculated by using item by item agreement. The formula for calculating IOA was number of items agreed/total number of items on the checklist, multiplied by 100% to yield a percent agreement. IOA was 96% for Lucy (ranged from 91% - 100%), 90% for Ana (ranged from 85% - 95%), and 95% for Marilyn (ranged from 87% - 99%).

Experimental Design

A multiple baseline across participants design was used to evaluate the effect of video modeling on staff implementation of the PEAK curriculum. Phases included baseline, video modeling, video modeling with implementation checklist, and generalization probes.

Procedure

Baseline. Participants viewed the informational slideshow with voiceover that detailed the protocol for teaching material, prompting, and data collection for PEAK programming. Trainees moved through the material at their own pace. At the end of the training, participants could ask any questions about the material.

The experimenter then instructed the participants to implement a PEAK program with an adult confederate, during which baseline data were collected. The primary researcher and a trained research assistant served as the confederates. Participants were provided with the program instruction sheet, a direct training data sheet, and any stimuli necessary to implement programming. One session included 10 trials total. Responses occurred in a random order pre-assigned to the confederate. Feedback was not provided following sessions.

Video modeling. Participants then viewed the video model demonstrating the protocol for teaching material, prompting, and data collection for PEAK programming. At the end of the video, participants could ask questions about the material.
Immediately after viewing the video, participants were instructed again to implement the same PEAK programming with an adult confederate. Participants were provided with the program instruction sheet, a direct training data sheet, and any stimuli necessary to implement programming. Responses occurred in a random order preassigned to the confederate. Additionally, participants viewed the videos prior to each session in the video modeling phase. Video modeling continued for participants until they had implemented the procedure with at least 95% accuracy for two consecutive sessions. Feedback was not provided following sessions.

**Video modeling with implementation checklist.** If criterion was not achieved in the video modeling phase, the participant was supplied with the implementation checklist during sessions. The protocol was identical to the video modeling phase, but participants also collected their own data during sessions using the checklist. Participants were prompted to fill out the checklist after each trial.

**Generalization probes.** Once a participant had reached 95% with a confederate, she was instructed to implement a novel PEAK program with a child in situ. Participants were provided with the program instruction sheet, a direct training data sheet, and any stimuli necessary to implement programming, but did not have access to the training materials or videos from previous phases.

**Treatment Fidelity**

Treatment integrity data was calculated for the informational slideshow and video models using the checklists in Appendices E and F. These checklists featured the same items used in the implementation checklist, and were used to ensure all necessary information was included in the training materials. Percent treatment fidelity was calculated by dividing the number of scored
items correct over the total number of items and multiplying by 100%. Treatment integrity was 100% for the informational slideshow and 100% for the video model.

Social Validity

A 5-point Likert-type questionnaire was given to each participant following intervention. Questions assessed how helpful participants found the video modeling intervention and if they would be interested in using video modeling to learn other skills. An open-ended item was included to provide participants with an opportunity to include suggestions they might have to improve the intervention. See Appendix G for the social validity questionnaire.
CHAPTER THREE:

RESULTS

Figure 1 shows results for the three participants across all phases of the study. The mean baseline score for Lucy was 40.3%. She improved to mastery after 5 sessions in the video modeling phase. The mean baseline score for Ana was 68.4%. She also improved to mastery after 2 sessions in the video modeling phase. The mean baseline score for Marilyn was 60.8%. Her mean score improved to 80.5% in the video modeling phase, and mastery was achieved with the addition of the implementation checklist after 5 sessions. Marilyn’s average score in generalization probes was 91% across four distinct programs.

All participants indicated a score of 5 when asked “Was the video modeling training for PEAK helpful?” Lucy and Marilyn scored 5 and Ana scored 4 for “How would you rate your ability to implement PEAK following the training?” Lucy and Ana scored 5 and Marilyn scored 4 for “Would you be interested in using video modeling to learn other job-related skills? Suggestions for improving the training included having more examples of scenarios in the model and a more discrete breakdown of step-by-step instructions.
CHAPTER FOUR:
DISCUSSION

Results from this study indicate that video modeling was effective in improving implementation of the PEAK curriculum. All three participants showed improved mean scores from baseline when video modeling was implemented. However, Marilyn required the addition of the implementation checklist to achieve mastery. Results are consistent with other studies that indicate video modeling can be used to improve job skills (Vladescu et al., 2012). However, the addition of a self-monitoring job aid such as a checklist may be necessary to improve skills to mastery levels, as was the case for Marilyn.

It is unclear why Marilyn required the additional checklist phase. She was the only participant with experience in implementing verbal behavior programming, so perhaps prior training had resulted in habits that interfered with her correctly implementing the PEAK program. It is also interesting to note that in the video modeling phase, she consistently erred on the same step of the checklist (minimizes time between trials). After two sessions in the checklist phase where performance had not improved, she rearranged her environment in a manner that resulted in less time between trials and, consequently, a sharp improvement in her performance. This suggests that the addition of a checklist may be effective in prompting trainees to engage in correct behaviors.

As PEAK is advertised as a curriculum suitable to caretakers with all levels of ABA experience, it is also interesting to note that Ana showed significant improvement between her first and second baseline sessions, with no additional training or feedback. This lends evidence to
both the accessibility of PEAK and the value of in situ practice, as merely more exposure to and experience with the program appeared to improve employee performance.

One limitation of this study was time constraints. Due to the expectations of the company involved, participants had to move through preliminary training during limited hours across the span of a week, so they would then be available to observe therapy sessions that included PEAK programming. PEAK training was a portion of this preliminary training, and participants needed to demonstrate mastery of the skill before beginning observations. As a result, the video training for this study was very brief and included only one example of a PEAK program being run. Additionally, the video modeling phase was very brief for Marilyn so that she could have the opportunity to master the skill in the video modeling with implementation checklist and be prepared to move into observations. Future studies may benefit from being conducted with fewer time restraints and a more flexible training schedule.

Further research is also necessary to verify the generalization of PEAK skills learned through video modeling. Ana left the company shortly after reaching mastery criteria, so generalization data was not collected. Generalization data for Lucy has also not been collected to date. As generalization probes were only conducted for one participant, future studies would benefit from more consistent generalization data. Additionally, the video training used in this study was designed specifically for the Direct Training module of PEAK. Skills necessary for the Direct Training module are also essential for the other three modules of the curriculum. Generalization probes for Marilyn included programs not only from the Direct Training module of the PEAK curriculum, but also from the Generalization and Equivalence modules, and indicated generalization across multiple programs in varying modules. However, it is unclear if this is a result of the training received in the study or because of additional training received
during observation and hands-on experience before the generalization data was collected. Further research would benefit from examining if training in one module can generalize to performance in others.

It would also be beneficial to explore whether the implementation checklist alone would be effective in improving implementation from baseline. Adding the implementation checklist required no additional cost or time to training, yet was effective in improving Marilyn’s scores to mastery. If a checklist alone would be sufficient, time spent in viewing the videos may be unnecessary. It would also be worth exploring if the addition of the implementation checklist is more efficient than providing feedback. In this study, Marilyn required 4 sessions in the checklist phase to achieve mastery; however, she was consistently making the same single error across each trial. It is possible that receiving feedback on that one error would have improved her performance more quickly than the addition of the checklist. To conclude, this study adds to the literature by showing that a short video model can be effective in improving skills needed to be successful in the implementation of the PEAK curriculum.
REFERENCES


Figure 1. Results for Lucy, Ana, and Marilyn. Each symbol represents a different program.
APPENDICES
Appendix A: Program Instruction Sheet

Program Instruction Sheet

Program Name: Match Objects (3D) – 6J (Direct Training)

Goal:
- When presented with a neutral sample item and an array of two items, the participant will choose the item that matches the sample.

Materials Needed:
- Everyday objects known to the participant (non-preferred).

Instructions:
- Place 2 different items or edibles in front of the participant.
- Give participant a non-preferred, everyday item to match.
- Say, “Pick the same.”

Typical Stimuli:
- Items or foods that are not highly preferred, color blocks, pictures of common items, silverware, cups, etc.

<table>
<thead>
<tr>
<th>Stimulus:</th>
<th>Stimulus:</th>
<th>Stimulus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>23</td>
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<td>4</td>
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<td>9</td>
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<td>29</td>
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<tr>
<td>10</td>
<td>20</td>
<td>30</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
<th>Date Introduced</th>
<th>Date Mastered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0= no response after multiple attempts at prompts
2= multiple prompts or reduced stimulus array eventually evoked a response
4= 2 prompts at most evoked the response with full stimulus array
8= 1 single prompt (either vocal or visual)
10= independent accuracy on response with no prompt
Appendix B: Direct Training Data Sheet

Learner Initials: ________

Program Name: ______________________

<table>
<thead>
<tr>
<th>Trial Number</th>
<th>Stimulus Number</th>
<th>Response Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0 2 4 8 10</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0 2 4 8 10</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0 2 4 8 10</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0 2 4 8 10</td>
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<td>0 2 4 8 10</td>
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<td>9</td>
<td>0 2 4 8 10</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0 2 4 8 10</td>
<td></td>
</tr>
</tbody>
</table>

Total Response Score: ______ / 100

Date: ________     Instructor Initials: ____

23
Appendix C: PEAK Implementation Checklist

<table>
<thead>
<tr>
<th>Task</th>
<th>Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arranges stimuli correctly for trial</td>
<td>1</td>
</tr>
<tr>
<td>Presents the SD/Question clearly</td>
<td>2</td>
</tr>
<tr>
<td>Allows 5 seconds for response</td>
<td>3</td>
</tr>
<tr>
<td>Provides reinforcement if correct</td>
<td>4</td>
</tr>
<tr>
<td>If incorrect, represents the SD and provides appropriate prompt</td>
<td>5</td>
</tr>
<tr>
<td>Records trial correctly on data sheet</td>
<td>6</td>
</tr>
<tr>
<td>Allows appropriate amount of reinforcement</td>
<td>7</td>
</tr>
<tr>
<td>Minimizes time between trials</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

Correct: ___________  Incorrect: ___________  Percent Correct: ___________
## Appendix D: Implementation Checklist Scoring Guide

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Arranges stimuli correctly for trial** | - Materials are within reach and of visible to client  
- Materials from previous trial are cleared from area |
| **Presents the SD/Question clearly** | - Sd is clear enough to be heard  
- Consistent with instruction sheet; Sd is always the same (“Pick the Same” or “Match” is acceptable)  
- For 2<sup>nd</sup> presentation, “Try again” is also appropriate |
| **Allows 5 seconds for response** | - Gives client 5 seconds to begin responding (any meaningful movement) before prompting  
- Prompts within 10 seconds of presenting the initial Sd |
| **Provides reinforcement if correct** | - Vocally indicates correct response to client  
- Scored as incorrect if no reinforcement is given for correct response  
- Scored as incorrect if correct response is never prompted |
| **If incorrect, represents the SD and provides appropriate prompt** | - Follows prompting hierarchy  
- 10 - Correct response on initial Sd  
- 8 - Represent Sd  
- 4 - Provide an additional prompt to presenting Sd  
- 2 - Physical prompting or reducing the array  
- Scored as incorrect if correct response is never prompted |
| **Records trial correctly on data sheet** | - Records correct score in the correct spot  
- Scored as incorrect if score is recorded as zero |
| **Allows appropriate amount of reinforcement** | - Relative to other trials in the session, provides greater/more intense praise for scores of 8 and 10 than other scores  
- Relative to other trials in the session, provides less/less intense praise for scores of 2 and 4 than other scores  
- Scored as incorrect if no reinforcement is given for correct response  
- Scored as incorrect if correct response is never prompted |
| **Minimizes time between trials** | - No more than 5 seconds from the last instance of looking up from data sheets to presenting the SD |
## Appendix E: Treatment Fidelity Checklist – Informational Slideshow

<table>
<thead>
<tr>
<th>Item</th>
<th>Was the item reviewed in the slideshow?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arranges stimuli correctly for trial</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Presents the SD/Question clearly</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Allows 5 seconds for response</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Provides reinforcement if correct</td>
<td>Yes  No</td>
</tr>
<tr>
<td>If incorrect, represents the SD and provides appropriate prompt</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Records trial correctly on data sheet</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Allows appropriate amount of reinforcement</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Minimizes time between trials</td>
<td>Yes  No</td>
</tr>
</tbody>
</table>
### Appendix F: Treatment Fidelity Checklist – Video Model

<table>
<thead>
<tr>
<th>Item</th>
<th>Was the item implemented in the video?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arranges stimuli correctly for trial</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Presents the SD/Question clearly</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Allows 3 seconds for response</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Provides reinforcement if correct</td>
<td>Yes/No</td>
</tr>
<tr>
<td>If incorrect, represents the SD and provides appropriate prompt</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Records trial correctly on data sheet</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Allows appropriate amount of reinforcement</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Minimizes time between trials</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Appendix G: Social Validity Questionnaire

Was the video modeling training for PEAK helpful?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

How would you rate your ability to implement PEAK following the training?

<table>
<thead>
<tr>
<th>Incapable</th>
<th>Somewhat capable</th>
<th>Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Would you be interested in using video modeling to learn other job-related skills?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Possibly</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

How would you suggest the training be improved?


Other comments:


Appendix H: USF IRB Approval

August 13, 2018

Kelsie Thompson
ABA-Applied Behavior Analysis
Tampa, FL 33612

RE: Expedited Approval for Initial Review
IRB#: Pro00035689
Title: Using Video Modeling to Improve Staff Implementation of the PEAK Relational Training

Study Approval Period: 8/12/2018 to 8/12/2019

Dear Ms. Thompson:

On 8/12/2018, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
Protocol, Version #1, 8.10.18.docx

Consent/Assent Document(s)*:
Adult IFC, Version #1, 8.10.18.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:
Appendix I: Consent Form

Study ID: Pro00035689 Date Approved: 8/12/2018

Informed Consent to Participate in Research Involving Minimal Risk

Pro # 00035689

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:

Using Video Modeling to Improve Staff Implementation of the PEAK Relational Training System

The person who is in charge of this research study is Kelsie Thompson/ This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by Kim Crosland.

The research will be conducted at BCOTB.

Purpose of the study

The purpose of this study is to evaluate the effectiveness of using video modeling to train staff in implementing the PEAK- DT curriculum.

Why are you being asked to take part?

We are asking you to take part in this research study because you are an employee at BCOTB who has not had experience in implementing the PEAK curriculum.

Study Procedures:

If you take part in this study, you will be asked to:

- Participate in the implementation of PEAK programming with an adult confederate across a series of conditions. Conditions will include a variety of training methods, including an informational approach, video modeling, and potentially the use of a checklist and/or feedback.
- Complete a questionnaire with items pertaining to your satisfaction with the study.
• Participate for a period of approximately 5-20 sessions (10-20 minutes each) during regular training hours across 1-15 weeks
• Agree to the videotaping of implementation sessions. Recordings will be accessed by the research team alone and will be labeled by pseudonym and not your actual name. Recordings will be held in a password protected digital storage space for 5 years after the study is complete, at which point they will be deleted.

Total Number of Participants
About 8 individuals will take part in this study at USF.

Alternatives / Voluntary Participation / Withdrawal
You do not have to participate in this research study.

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not to participate will not affect your job status, employment record, employee evaluations, or advancement opportunities.

Benefits
The potential benefits of participating in this research study include:
• Improved implementation of PEAK programming.

Risks or Discomfort
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation
You will receive no payment or other compensation for taking part in this study.

Costs
It will not cost you anything to take part in the study.

Privacy and Confidentiality
We will keep your study records private and confidential. Certain people may need to see your study records. Anyone who looks at your records must keep them confidential. These individuals include:
• The research team, including the Principal Investigator, faculty advisor, research assistants and all other research staff.
• Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.
• Any agency of the federal, state, or local government that regulates this research.
• The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.

• The company where the research is taking place (BCOTB). While general information about the results of the study will be shared, no identifying information about individual employee performance will be included.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Kelsie Thompson at 813-244-6098.

If you have questions about your rights as a participant in this study, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

Consent to Take Part in this Research Study

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

_____________________________________________  __________________________
Signature of Person Taking Part in Study       Date

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in their primary language. This research subject has provided legally effective informed consent.

_____________________________________________  __________________________
Signature of Person obtaining Informed Consent       Date

Printed Name of Person Obtaining Informed Consent