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Can Using One Trainer Solely to Deliver Prompts and Feedback During Role Plays Increase Correct Performance of Parenting Skills in a Behavioral Parent Training Program?

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Can Using One Trainer Solely to Deliver Prompts and Feedback During Role Plays
Increase Correct Performance of Parenting Skills in a Behavioral Parent Training
Program?

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Applied Behavior Analysis
College of Graduate School
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Services Program, modeling

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Dedication

I dedicate this text to my late mother, Ann E. Cripe, who believed in me when I did not believe in myself, and to Diana and Nuri, the best family I could ever hope for.

Acknowledgments

I would like to acknowledge David Geller, Terresa Kenney, Bryon Neff and Stacie Neff for their support, personal as well as technical. I also must acknowledge my fellow students who assisted with data collection and provided moral support, my advisor, Dr. Kim Crosland and Dr. Ray Miltenberger. Finally, I am grateful for Dr. Susan M. Havercamp's assistance with the statistical analysis of the data presented herein.

Table of Contents

List of Tables	ii
List of Figures	iii
Abstract	iv
Introduction	1
Method	7
Behavior Analysis Services Program	7
Participants and Setting	7
Group Selection and Assignment	9
Informed Consent	10
Training	10
In-class role play assessments	13
Independent Variables	13
One Trainer	13
Two Trainers	13
Pre and Posttests	14
Interobserver Reliability	14
Experimental Design and Analysis	15
Results	16
Discussion	19
References	23
Appendices	26
Appendix A: Tool Checklists	27
Appendix B: Role Play Scenarios	31

List of Tables

Table 1.	Caregivers in the two trainer group arranged by type.	8
Table 2.	Caregivers in the one trainer group arranged by type.	9

List of Figures

Figure 1.	Mean Group Pre and Posttest Scores	16
Figure 2.	Biological and Foster/Adoptive Parents Mean Scores	18

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ABSTRACT

Behavioral Parent Training refers to a broad range of instructional programs that teach parents and other caregivers ways to build and change behavioral repertoires of children. Most, if not all, such programs employ Behavioral Skills Training (modeling, prompting, role-play practice and feedback) to teach parenting skills. However, specific ways to use prompting during role plays have not been described in the behavioral parent training literature. The present study compared two methods of conducting role plays during parent training. A between group, pretest/posttest design was used to evaluate and compare the effect of using one versus two trainers on the role-play performance of parents and other caregivers involved in the child dependency system. Although both groups' posttest scores improved, there was no statistically significant difference between the one and two trainer groups. It was determined that foster and adoptive parents performed better on posttest measures than did biological parents and relative caregivers, regardless of group assignment.

Introduction

Behavioral Parent Training (BPT) is a broad term used to describe various training programs that address the acquisition of skills by parents or other caregivers which, when such skills are used, are believed to have some positive effect on the behavior of children (Graziano & Diament, 1992). BPT programs have taught parents to reinforce appropriate behaviors (O'Dell et al., 1982) withhold reinforcement for inappropriate behavior (Eyberg & Matarazzo, 1980) and, in some cases, punish inappropriate behavior (Eyberg & Robinson, 1982). Parents have been taught to use reinforcement for compliance with requests, while ignoring non-compliance (Ducharme, Atkinson & Poulton, 2001) and to use reinforcement for compliance combined with a time-out procedure for a failure to comply within a specified latency period (Forehand & King, 1974; 1977).

Some programs have involved teaching parents to use a variety of combinations of reinforcement, extinction, prompting, rule-stating and time-out depending upon various dimensions of the child's behavior, such as whether or not it is potentially physically harmful to self, others or property (Van Camp, Borrero & Vollmer, 2003; Van Camp et al., *in press*). Additionally, BPT programs have taught specific interaction skills (Eyberg & Matazarro, 1980; Van Camp et al., 2003; Van Camp et al. 2007, *in press*)

meant to improve relationships between child and parent by altering the parent's verbal and affective behavior.

Common among many BPT training packages is the combination of didactic instruction (e.g. lecture) with modeling, role-playing and the contingent delivery of feedback based upon performance (Ducharme et al., 2001; Forehand & King 1977; Marcus, Swanson & Volmer 2001; Sandler, Van Dercar & Milhoan, 1982). Instruction that employs modeling, role-playing, and the contingent delivery of feedback for correct and incorrect performance is known as Behavioral Skills Training (BST). It is typically used in cases where individuals must learn appropriate responses to situations that, due to their nature, have to be staged (Poche, Brouwer & Swearingen, 1981). BST is often used in training individuals to react to potentially dangerous situations such as the presence of a firearm (Himle, Miltenberger, Flessner & Gatheridge, 2004) a potentially abusive person (Poche, Yoder & Miltenberger, 1988) and fires (Jones, Kazdin & Haney 1981).

However, a large number of BPT programs cite the use of BST techniques in teaching parents to respond appropriately to child behavior in staged settings (Ducharme et al., 2001; Eyberg & Robinson, 1982; Forehand & King, 1977; Van Camp, Vollmer & Borrero, 2003; Wolfe et al., 1982). For example, Van Camp et al. (*in press*) described a BPT program that presented parents with nine techniques to use with children to reduce inappropriate behavior, teach appropriate alternative behavior and improve the quality of parent/child interactions. During class sessions, the trainers demonstrated the techniques and then role-played with the parents using situations that were frequently encountered in the home environment. Correct responses were prompted as necessary during the role-

plays, with feedback being delivered as to which steps of the relevant technique were completed and which ones were not.

In the BPT literature, detailed descriptions of the ways in which modeling, role-playing, prompting and delivery of feedback are used are often not provided. For example, Ducharme et al. (2001) stated that a 45 minute session using, “modeling, rehearsal and performance feedback,” was conducted with two parents, but did not describe the procedure (p.860). Forehand and King (1977) noted that after a reinforcement procedure was discussed with a mother in training, therapist modeling of additional techniques and practicing in a role-play situation was “optional,” but did not describe the manner in which these should be conducted (p.99). Smagner and Sullivan (2005) cited the use of teaching methods including, “...role-plays followed by verbal feedback,” (p.433). Sandler et al. (1982) mentioned the use of role-plays where the trainer modeled desired parenting techniques while a participant acted the part of the child. Next, the trainer acted as the child while the participant attempted to perform the skills that had just been demonstrated. However, the authors provided no specific descriptions of prompting or delivery of feedback. It appears that in these studies, it was assumed that the types of models, prompts and feedback necessary for instruction in the BPT program were either obvious or widely known. However, the level of detail in describing the use of BST techniques in BPT programs may be insufficient for replicating (Baer, Wolf, & Risley, 1968).

One goal of BPT is to establish stimulus control sufficient for a parent’s use of various techniques upon a child’s emitting a particular behavior or when taking part in a

certain activity such as feeding or toilet training. For example, a child's picking up trash, or sharing toys with a sibling could, with training, become a discriminative stimulus for the parent's contingent delivery of descriptive praise. BST procedures, such as role-playing, prompting and contingent delivery of feedback are employed so that a parent may rehearse responding in the presence of stimuli similar to those that are encountered in-situ. Therefore, it is important that BST techniques be properly employed by BPT trainers so that transfer of stimulus control from ex-situ to in-situ conditions may occur (Miltenberger, 2004).

Generalization of a particular parenting skill from training to the home environment may be said to have taken place if it occurs in-situ when relevant stimuli are present (Stokes & Baer, 1977). Examples used in training must, to the greatest extent possible, incorporate stimuli common to the environment in which parents will be expected to use skills being taught (Stokes & Baer, 1977). For example, if a parent in training has a child who cries and screams for ice cream, then a trainer acting as a child in a role-play designed to teach an appropriate parental response should engage in similar behavior with similar dimensions (i.e., frequency, volume, tone of voice).

In the BPT program described by Van Camp and colleagues, (*in press*) it was often necessary that one trainer conduct role-playing, acting as the child while also delivering corrective feedback and praise, with small groups of parents. This entailed a trainer alternating between acting as the child and delivering prompts and feedback in role-plays. This is analogous to two boxers sparring while one delivers instructions to the other or two actors rehearsing a scene while one supplies the other with prompts for

missed lines. In any of these cases, the individual who receives prompts and feedback while rehearsing may learn to respond to stimuli other than those most relevant to the in-situ environment.

Bondy and Frost (2001) discussed prompting strategies in a description of the Picture Exchange Communication System (PECS), a language training program for children with autism. The basic assumption underpinning the PECS training is that in verbal interactions between individuals, the verbal behavior of one (the speaker) is under the stimulus control of the other (the listener) (Bondy & Frost, 2001; Skinner, 1957). Thus, the PECS training uses two trainers to conduct communication training with a child with autism. One acts solely as the “communication partner,” while the other delivers physical prompts in a manner so that no social interaction takes place between the second trainer and the child. The authors’ stated purpose for this strategy was to have the child respond only to those stimuli that are being trained and not to prompts from either trainer. An example of this procedure involves placing preferred items before the child with a communication partner seated facing her. When the child attempts to pick up an item, the second trainer physically prompts her from behind to pick up a picture of the item and hand it to the communication partner. The child then receives the item for a brief period of time. The child’s selection and handing over of the picture is (ostensibly) reinforced by gaining access to the item; the “exchange” of picture for item constitutes a discrete instance of verbal behavior (Bondy & Frost, 2001).

As Bondy and Frost (2001) suggest, training individuals to respond to the on-going behavior of others may be made more difficult when prompts that are not germane

to such interactions intervene. Thus, the authors chose to have one individual act solely as the deliverer of physical prompts to a child who was learning to mand. In the case of using role-plays to approximate in-situ conditions, having an actor alternate between engaging in child-like behavior and delivering prompts may interfere with the establishment of stimulus control with respect to the stimuli relevant to the skill being taught (i.e. parenting skills). To evaluate this within the context of parent training this study compared the use of two methods of conducting role-plays within a BST training environment. The use of one trainer who acted as the child-model while also delivering prompts and feedback was compared with the use of two trainers, with one acting solely as the child model and the other delivering prompts and feedback. It was hypothesized that the performance of those individuals who were exposed to the use of two trainers, as described earlier, would improve over those who were only exposed to one trainer. If it were found that the use of two trainers for role-plays in a BPT program had a significant effect on the performance of participants, additional resources for staffing such programs might be warranted. In addition, the results of this study may suggest further avenues for research into ways to program for skill generalization in the area of behavioral parent training.

Method

Behavior Analysis Services Program

The behavioral parent training curriculum used in the study was developed and promulgated by the Behavior Analysis Services Program. The Behavior Analysis Services Program (BASP) provides behavior analytic services to clients of the Florida child welfare system. It is funded by the Florida legislature and administered by the University of South Florida and the University of Florida. Teams of behavior analysts and senior behavior analysts (i.e., supervisory staff) are located throughout the state in service districts as defined by the Florida Department of Children and Families.

Local private, not for profit, community-based care organizations deliver services in the areas of foster care, adoption and family reunification. The BASP works with these organizations to provide training to foster, adoptive and biological parents, as well as residential and care management staff. The services provided by the BASP all are behavior analytic in nature and include competency-based training, functional behavioral assessment and provision of technical assistance.

Participants and Settings

The participants were biological parents or alternate caregivers (e.g., foster parents) involved with a community based care agency and referred to the BASP for training. Biological parents were referred for training in order to meet the requirements of

a court-approved case plan. Some foster parents were referred by licensing agencies due to concerns about behavior management practices or because they were providing care for a child or children who engaged in challenging behaviors. Other foster and potential adoptive parents were referred for training prior to having children placed in their homes. Finally, some foster, adoptive and other alternate caregivers received training due to having sought out help in providing care to children with challenging behavior (i.e. without any requirement from any agency or entity). Demographic and personal characteristics varied across participants. Tables 1 and 2 show demographic characteristics for participants and are arranged by group assignment.

Table 1

Caregivers in the One-Trainer Group (Group B) arranged by type

<i>One Trainer Group B</i>	<i>Caregiver Type</i>	<i>Gender</i>	<i>Race</i>	<i>Pretest Score (percent of correct steps)</i>	<i>Posttest Score (percent of correct steps)</i>
1	biological	F	W	48	56
2	biological	M	W	48	60
3	biological	M	W	34	45
4	biological	F	W	18	58
5	relative	F	B	24	45
6	biological	F	W	24	60
7	biological	M	W	40	74
8	foster/adoptive	F	W	22	79
9	foster/adoptive	M	W	41	75
10	foster/adoptive	F	W	54	88
11	foster/adoptive	F	W	26	53
12	foster/adoptive	M	W	61	98
13	foster/adoptive	F	B	43	76
14	staff	F	B	36	70

Note . “Biological” denotes a parent of a dependent child, “relative” denotes a blood relative of a dependent child. “Foster/adoptive” refers individual who have or will be taking dependent children into their homes. “Staff” refers to individuals who regularly interact with dependent children and their families in a variety of settings.

Table 2

Caregivers in the Two-Trainer Group (Group A) arranged by type

<i>Two Trainer Group A</i>	<i>Caregiver Type</i>	<i>Gender</i>	<i>Race</i>	<i>Pretest Score (percent of correct steps)</i>	<i>Posttest Score (percent of correct steps)</i>
1	biological	F	W	46	48
2	biological	F	W	37	42
3	relative	F	W	26	31
4	biological	M	W	26	57
5	relative	F	B	26	88
6	biological	F	W	27	71
7	relative	F	B	36	59
8	foster/adoptive	M	W	47	66
9	foster/adoptive	M	W	36	74
10	foster/adoptive	F	B	35	88
11	foster/adoptive	F	W	62	92
12	staff	F	W	59	68

Note. "Biological" denotes a parent of a dependent child, "relative" denotes a blood relative of a dependent child. "Foster/adoptive" refers individual who have or will be taking dependent children into their homes. "Staff" refers to individuals who regularly interact with dependent children and their families in a variety of settings.

The training took place in two settings. One was a large training room at a local university. The other was a training room on the grounds of a residential facility for dependent children.

Group Selection and Assignment

Two experimental groups were formed. Participants were selected from a list of referrals maintained by the BASP office. These referrals came from case managers, other agency staff and participants themselves (reasons for individual referrals to the BASP

were mentioned earlier). Classes were drawn from the referral pool in first-referred, first-served order as mandated by contractual agreement with the local child welfare agency.

Participants were assigned to either group following the administration of the course pre-test. In order to control for the possibility that high or low scoring individuals could form the preponderance of either group, group assignment was made as follows. Pre-test scores were rank ordered from highest to lowest across all participants. Group assignment from highest to lowest score was made in this sequence: A B B A, repeating as necessary. Individuals whose pretest scores were 80 per cent or greater were excluded from the study. One potential participant was excluded from the study as a result of exceeding the upper limit for pretest scores.

Informed Consent

All participants, regardless of experimental group assignment, received the standard BASP Tools for Positive Behavior Change curriculum training. Informed consent was obtained to take part in the program per the standard practice employed by the BASP. The BASP program operates under a service provision agreement with the Institutional Review Board. An exemption for obtaining specific informed consent from participants was granted for this study under exempt category **45 CFR 46.101(b)(1)** which covers the evaluation and/or comparison of educational strategies, techniques or curricula.

Training

The Tools for Positive Behavior Change is a training package that focuses on eight, task-analyzed techniques (or tools) for adults to use across a variety of routine

interactions with children and adolescents. Each technique is based on empirically validated behavioral procedures such as differential reinforcement, extinction, time-out and contingency management (Van Camp et al., *in press*).

For this study, four of the eight tools were used for evaluation of the independent variable. The exact same curriculum was used for both classes so that instruction in the four relevant techniques was no different in one class than the other. Class session 1 consisted of an introduction and overview of the course and pre-tests. Class 2 covered basic behavioral principles such as the potential effects of consequences on the future likelihood of behavior. The remainder of the classes included instruction of the tools that comprise the curriculum.

As stated previously, the current study concentrated on four of the eight tools; however, participants received instruction in the additional tools. The four tools of interest were covered in classes 3 through 5, in the order that they appear herein (A complete set of task-analyses for each tool is attached in appendix 1). Tool 1; *Stay Close* was a cluster of adult behaviors is intended to enhance interactions with children so that adult attention is established as a reinforcer. The use of open-ended questions, statements of empathy and concern, along with the maintenance of affect appropriate to the situation (e.g. facial expressions, tone of voice) were covered. Tool 2; *Use Reinforcement* was a series of steps that guides adults in the delivery of various stimuli (e.g., descriptive praise, items, privileges, pleasant touch) contingent upon a child's performance of desirable behavior. Tool 3; *Pivot* consisted of withholding attention while a child engaged in minor inappropriate behavior ("junk behavior") that would not be harmful to anybody or

anything and could be ignored with little chance of harm occurring. When the inappropriate behavior ceased the adult then provided attention, as in a differential reinforcement procedure. Tool 4; *Redirect/Use Reinforcement* was a series of steps for interrupting behavior that may cause injury and thus could not be ignored *or* for behavior that occurred because an acceptable alternative did not exist in the child's repertoire. In either case, on-going behavior would be interrupted, and an appropriate alternative then prompted. Reinforcement would be delivered by the adult contingent upon the child's performance of the alternative behavior. This skill is also essentially a differential reinforcement procedure (Van Camp et al., *in press*).

In each class, instruction began with a didactic presentation of the session materials with participants making comments, asking questions and being encouraged to respond. The tool or tools slated for that session were typically demonstrated early in the session, with some components broken out and covered in more detail (e.g., *Stay Close* was demonstrated across a few scenarios that involved children of different ages with empathy statements relevant to each situation). Trainers demonstrated the tools by role-playing different scenarios that cover a variety of stimulus conditions likely to be encountered by adult caregivers (e.g., age of the child, the activity at hand). For example, the tool *Redirect/Use Reinforcement* was demonstrated with a young child running near a street, an older child climbing on a counter to get something or an older child trying to open a sealed compact disc with a sharp knife.

In class role-play assessments

At the end of each class session, participants were broken into the two assigned groups. The trainer told the group that they would be practicing the use of the skill just covered in class by role-playing with a trainer. The trainer blindly selected a written scenario from several different ones in an envelope (see Appendix B). Each group member was instructed to act as the parent in the role-play scenario and attempt to use the skill that was taught in that class.

Independent Variables

One trainer. In this condition, one trainer acted as the child as well as prompted participants during the in class role plays to complete steps that they missed per the checklist for the relevant skill. Thus, in order to deliver a prompt, she had to break the flow of the role-play, instruct the participant to complete a step and then re-assume the role of the child. For example, if a participant was to have provided a verbal prompt to the “child,” and did not, the trainer would stop the role-play and say something like, “Remember to say, ‘good job.’ Try again,” and then resume the role of the child.

Two Trainers. In this condition, one trainer acted as the child exclusively, while another prompted participants, when necessary, to complete steps per the relevant checklist for that skill. The trainer who portrayed the child remained in character (i.e., continued to engage in “child” behavior) while the second trainer delivered prompts as necessary for each participant to correctly perform each step. For example, if the participant was to get within arm’s reach of the “child” and failed to do so, the prompter would say something like, “Get within arm’s reach,” while the “child” continued to

behave in a way pertinent to the scenario (e.g., cry and stomp his feet). If the participant moved closer to the child, the prompter delivered immediate positive feedback. If the participant did not respond to the first prompt, then additional prompting sufficient to affect the correct response was issued.

Pre and Posttests

In order to evaluate the effect of the independent variable, each individual took part in pre and post course role-play assessments. Individuals were presented with four standardized scenarios where a BASP trainer portrayed a child. The role play scenarios were the same for both pre and posttests. The scorers were blind to the group assignment of the participants. The participants were told the age of the child and given details about the situation. They were asked to do whatever they would normally do in each situation, given that they were in the position of the primary caregiver. Checklists were used to record completion of the steps relevant to each skill being assessed (see appendix 1). Each step could be scored as having occurred or not occurred. *Not applicable* was scored if the opportunity to perform a step was not available. This would apply if the trainer failed to perform one of the steps in the role play script. Scores were expressed as the percentage of steps correctly performed across all tools. No feedback was given to the participants as to their performance at any time during or immediately after the assessment.

Interobserver Agreement

Interobserver agreement was calculated for each skill assessment by comparing the responses of the two trained observers on each step of each tool. Observers were blind

to the group assignments of the participants. Agreement on any given step was said to have occurred if both observers scored the step in the exact same way (i.e. each scored “yes,” “no,” or “not applicable) (Van Camp et al., *in press*). Reliability scores for each pretest were added and divided by the number of pretests to determine the overall rate of agreement across pre-tests. Posttest interobserver agreement was determined in the exact same manner

Sixty-one percent of pre-course assessments and fifty percent of post-course assessments across participants were scored independently by a second trained observer in order to determine interobserver agreement. For pretests, average interobserver agreement was 64 percent ($r = 52\%$ to 94%). For posttests, agreement was assessed on 50 percent of assessments. Average interobserver agreement for posttests was 93 percent ($r = 87\%$ to 100%).

Experimental Design and Data Analysis

A between group, pretest/posttest design was used to evaluate the effectiveness of the independent variable. Scores on each of the four tools are expressed as a percentage of correct steps per checklist and were derived by dividing the number of correct steps by the number of steps possible for each tool and multiplying the result by 100. Group means were derived by adding the percentage of correct steps of each individual and dividing the sum by the n of the group.

Results

Figure 1 shows the pre and posttest scores for both groups. Group A received the two-trainer treatment during role-plays. The mean pretest score for the two trainer group (group A) was 40 percent, $SD = 13.2$. The mean posttest score for the two trainer group was 65.3, $SD = 19.0$. For the one trainer group (group B), the mean pretest score was 37.2 percent, $SD = 13.0$. The mean posttest score was 66 percent $SD = 15.7$.

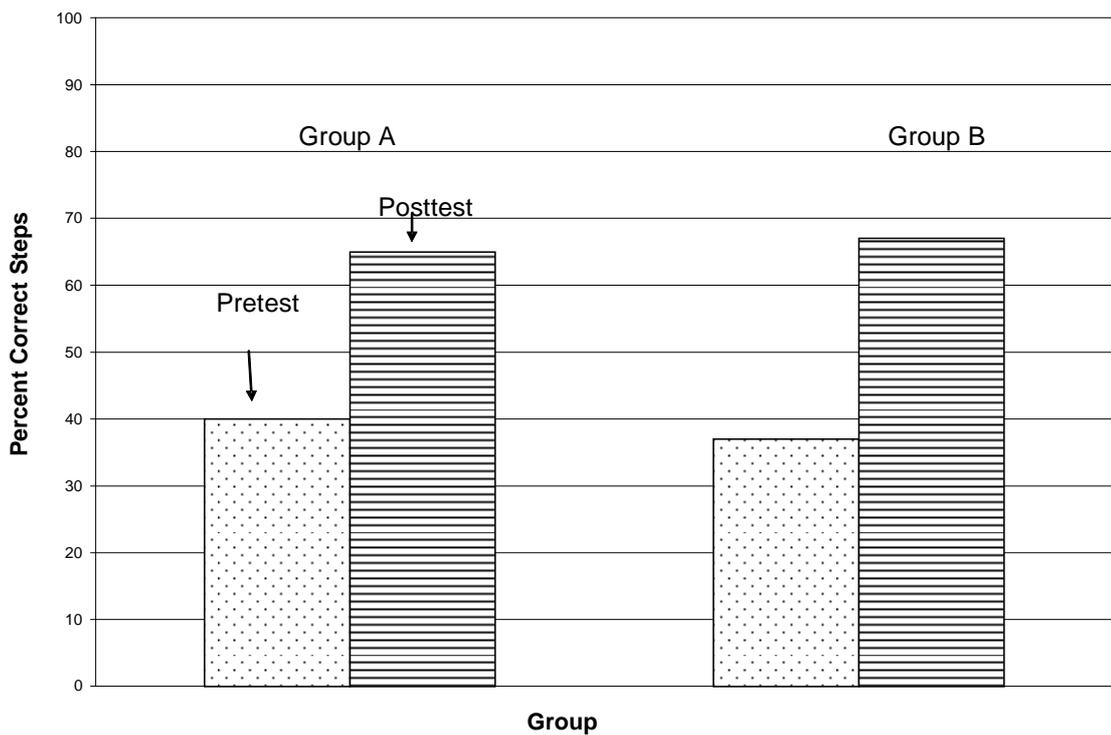


Figure 1. Mean pre and posttest scores for two trainer (group A) and one trainer (group B) groups.

A 2 x 2 mixed analysis of variance with one between group factor (group assignment – one vs. two trainers) and one within group factor (time of assessment – pre vs. posttest) was used to analyze the results. Overall, there was a main effect for time, $F_{(1, 48)} = 41.38, p < .001$ but no main effect for group, $F_{(1, 48)} = .021, ns$. There was no statistically significant time X treatment group interaction effect ($F_{(1, 48)} = .27, ns$). Thus, although each group's performance on the assessments improved over time, the use of one versus two trainers during BST did not appear to make any appreciable difference in the scores.

It was observed that foster and adoptive parents' scores appeared to be higher on posttests than the scores of biological parents and relative caregivers. A second 2 x 2 analysis of variance was conducted to assess the effects of time and caregiver type. There was a main effect for type of caregiver (i.e. foster/adoptive versus biological), $F_{(1, 48)} = 24.6, p < .001$, with the foster and adoptive parent group performing better overall and a main effect for time (see above). However, there was not a significant time X caregiver type interaction effect ($F_{(1, 48)} = 1.79, ns$) indicating the two caregiver groups had *similar* gains between pretest and post-test.

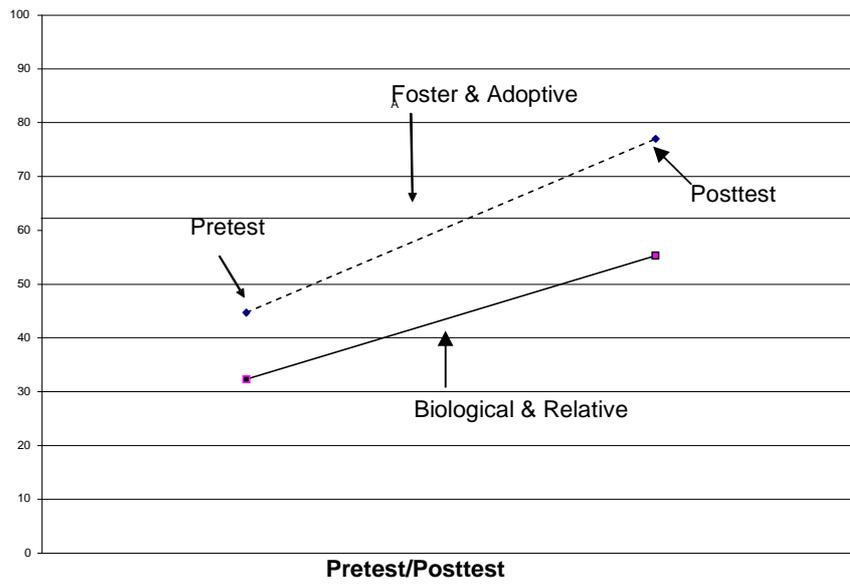


Figure 2. Mean pre and posttest scores by caregiver type.

Discussion

The present study looked at the effects of using an additional individual to provide prompts and feedback during role plays in a BPT class. A dearth of explicit explanations of such procedures in the BPT literature gave rise to this study (Ducharme et al, 2001). Given the outcome, that using an additional trainer did not produce a statistically significant difference between groups exposed to one and two trainer conditions, it may be concluded that behavioral parent training using curricula similar to that employed in this research can be conducted with fewer trainers. However, due to the small number of participants and the potentially confounding variable of type of caregiver discussed below, these results should be considered with caution.

A number of limitations of the present study should be considered. First, the one-trainer group, group B, had a higher proportion adoptive and potential adoptive parents who had also been exposed to state-mandated training that included a brief overview of the structure and key concepts of the BASP curriculum, but did not provide instruction of any of the four skills examined in the present study. This prior exposure could have had an effect on performance in that certain concepts (e.g. the importance of using positive reinforcement) had been covered. Second, regardless whether they were trained in either the one or two trainer group, foster and adoptive parents overall performed better on pre and posttests than did biological parents. Others have speculated that contextual variables such as socioeconomic disadvantage and family dysfunction might negatively impact outcomes of behavioral parent training (Assemany & McIntosh 2002). All of the

biological parents and relative caregivers in this study had been referred to parent training due to some difficulties sufficient to warrant the removal of children from their homes (e.g., substance abuse, excessive use of corporal punishment, neglect of a child). Future research in the use of instructional techniques in behavioral parent training program might take into account participant variables that could have an impact on outcomes. A potential avenue for research could involve the use of role play scenarios derived from each participant's experience so that training exemplars more are more closely related to conditions that a participant is likely to encounter. For example, if parent trainers were able to observe families prior to training, role play scripts could be developed that contain common and relevant exemplars. Although this does not directly address the hard variables such as socioeconomic status or substance abuse history, it would provide individuals with practice in conditions most similar to those they have encountered in the past and perhaps have a positive effect on future performance of skills.

Another limitation of the present study involves how prompting was delivered in cases where a participant did not emit a correct response upon receiving a verbal and/or gestural prompt. In such cases, the trainer repeated verbal and gestural prompts until the participant engaged in the relevant response. In other settings, such as when teaching a child to perform a skill, an instructor might use a touch prompt in order to get the child to engage in the required behavior, thus providing an opportunity to provide feedback on the child's performance more quickly. With adults in the current setting, using any physical prompts would not have been appropriate.

Difficulty in delivering effective prompts during role plays was also encountered when the relevant skill required a participant to demonstrate particular tone of voice or facial expression. When working with adults in this setting, a prompt to smile, or change vocal inflection might be met with resistance and, if the behavior is not emitted upon a verbal prompt, it likely will not occur at all during the role play. In fact, one of the individuals in the two trainer group stated that her tone of voice was “the way (I) talk,” and that she would not change it.

Interobserver agreement data was very low for the 61 percent of pretests sampled. In the future, additional training should be conducted with observers immediately prior to conducting pretests. Due to constraints of schedule and the number and availability of trained observers who were blind to participants’ group assignments, different observers were used for posttest than were used for pretests. Future efforts at collecting interobserver agreement data in this venue might benefit from employing the same observers throughout.

Future research might involve developing specific BPT curricula for targeted groups (e.g., biological parents). As others have noted, it may be the case that other, molar contingencies such as economic and social stressors have an overall deleterious effect on the outcomes of parent training. Therefore, programs that provide such supports as are relevant (e.g., assistance with transportation) might be more likely to be associated with improved outcomes on curricular measures. Another potential avenue for research might involve the use of numerous and varied exemplars of parent-child interactions that could be easily imitated by learners, prior to engaging in actual skills training. Finally,

adding explicit instructions for how to use behavioral skills training methodology to behavioral parenting training curricula could be useful for instructors and participants.

The present study did not demonstrate the superior effectiveness of using one trainer to act solely as the child during role plays in a behavioral parent training class. One potential confounding variable, the overall greater improvement on posttests for foster and adoptive parents, may have played a role in the findings. Future research in this area should control for the variable of caregiver type.

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Appendices

Appendix A-Role Play Checklists

Stay Close Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Get close to the child within 15 seconds of the Stay Close behavior (move toward child and be within arms reach, etc.).				
2. Touch appropriately (pat, hug, rub, etc.).				
3. Match facial expressions. (Appropriately reflect the emotion of the situation.) ¹				
4. Use appropriate tone of voice (voice matches situation, a neutral monotone is not good enough). ²				
5. Relax your body language within 15 seconds of the Stay Close behavior (relaxed, arms open, attentive, looking at child, etc.). ³				
6. Ask open-ended positive questions (what? who? how? when? where?). ⁴				
7. Listen while the child is speaking. Talk less than the child. (Do not problem-solve unless the child asks for help. Do not interrupt or abruptly change the topic.) ⁵				
8. Use empathy statements. (Act like a mirror and reflect the child's feelings, express understanding, caring, etc.) ⁶				
9. Avoid reacting to junk behavior. ⁷				
10. Stay cool throughout the process (no coercives).				

Trainer's Notes: After step 5, steps do not have to be completed in any particular order.

^{1,2,3} A single instance of a punitive, disgusted or inappropriate facial expression (step 3), tone of voice (step 4) or body language (step 5) during any part of the role play should be scored "no" for step 3, 4, or 5.

⁴ Only one open-ended question is needed to score a "yes" for step 6.

⁵ If problem-solving is used without child the asking for it, score "no" for step 7. If the caregiver begins to problem-solve, note if it occurs *before* or *after* the empathy statement.

⁶ Only one instance of an empathy statement is needed to score a "yes" for step 8.

⁷ A single instance of attending to junk behavior throughout the role play will be scored "no" for step 9.

Overall Comments: (Circle any coercives used: sarcasm/teasing; criticism; threats; arguing; questioning; logic; despair, pleading, hopelessness; force; taking away privileges/items/allowance; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Use Reinforcement Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Tell the child what behavior you liked (if this is appropriate).				
2. Provide a consequence for the behavior that matches the value of the behavior.				(Circle those provided): <ul style="list-style-type: none"> • Social Interaction • Verbal praise • Appropriate touch • Tangible item • Privilege • Break from task
3. Provide the positive consequence within 3 seconds of recognizing the appropriate behavior (if possible).				
4. Use sincere and appropriate facial expression, tone of voice and body language.				
5. Avoid reacting to junk behavior.				
6. Avoid coercion & punishment.				

Trainer's Notes:

- ¹ The Stay Close components must be used within 3 seconds of the caregiver responding to the appropriate behavior. If used after 3 seconds or not at all, score these items "no".
- ^{2, 4, 5} Score "No" if there is any instance of inappropriate expression, tone of voice, or body language after the first 3 seconds. If the observation is a competency check-off, caregiver should tell you how they would make sure the consequence is reinforcing without prompting.

Overall Comments: (Circle any coercives used: sarcasm/teasing; criticism; threats; arguing; questioning; logic; despair, pleading, hopelessness; force; taking away privileges/items/allowance; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Pivot Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Say nothing about the junk behavior. (For example: Don't say, "Stop that now!" or "Quit doing that!") ¹				
2. Do nothing to react to the junk behavior (for example: don't roll your eyes, stomp out of the room, cross your arms, stare.) ²				
3. Actively attend to another child, person, or activity. (For example: Read a book or praise another child for behaving appropriately.)				
4. Once the child who displayed junk behavior behaves appropriately, provide reinforcement for the appropriate behavior (social interaction, praise, touch, item, and privilege, break from task) within 10 seconds of recognizing the appropriate behavior of this child.				
5. Stay cool. No coercives.				

Trainer's Notes:

^{1,2} Score "No" if there is any response to the junk behavior, including laughing or any change of expression. However, if the caregiver realizes they have responded to the junk behavior and stops the response, note this in the Comments column and reinforce the acknowledgment and correction.

Overall Comments: (Circle any coercives used: sarcasm/teasing; criticism; threats; arguing; questioning; logic; despair, pleading, hopelessness; force; taking away privileges/items/allowance; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Redirect-Use Reinforcement Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Get within arm's reach of the child (before saying anything).				
2. Make sure the child stops the inappropriate behavior. (Use gentle physical guidance if necessary.)				
3. Calmly say something like, "Hey (child's name), I want you to (state the positive alternative behavior)."				
4. If the child does not begin to do the suggested activity within 3 seconds, model, or gently guide her/him to do the activity.				
5. Use Reinforcement when the child does the appropriate behavior (praise, touch).				
6. Reinforce the behavior within 3 seconds after the appropriate behavior begins. (Stopping serious behavior may be the appropriate behavior.)				
7. Say nothing and do nothing about junk behavior throughout the process.				
8. Stay cool and use no coercives.				

Overall Comments: (Circle any coercives used: sarcasm/teasing; criticism; threats; arguing; questioning; logic; despair, pleading, hopelessness; force; taking away privileges/items/allowance; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Appendix B-Role Play Scenarios

Stay Close

- General instructions
 - o Begin role play sitting or standing far enough away so the caregiver has to move towards you
 - o Make emotional comments like, “this sucks, I had a crappy/shitty day, it’s stupid, etc”, and engage in minor junk behavior; make these types of comments intermittently
 - o Stop these comments immediately once an empathy statement is made
 - o Avoid eye contact until the caregiver makes empathy statement
 - o If caregiver asks questions, answer them without talking too much
 - o Respond to any problem solving with more junk behavior
 - o If the caregiver doesn’t ask why you are upset, complain about your issue so that the role play continues.
 - o Remember that you want to talk to your caregiver.
- Scoring tips
 - o Watch the caregiver’s body language. Arms folded, hands on hips, standing over the top of the child and looking at things other than the child are not appropriate. Wait to see if they change.
 - o Getting close and relaxed body language must occur by the halfway point for it to be scored as “yes.”
 - o If an appropriate touch occurs, even at the very end, it is scored as a “yes.”
 - o End the role play when you have the information needed.
- Role Plays
 - o **Friend has moved away (official pre/posttest)**
 - o Someone made fun of my bike
 - o Just found out friend has cancer
 - o Someone at school is bullying me
 - o This boy took my lunch from me on the bus this morning.
 - o My favorite teacher is sick and we will have a new teacher for the rest of the year.
 - o My teacher asked me to read in front of the class today and I messed up and the class laughed at me.
 - o This girl at school is spreading rumors about me that are not true.
 - o This boy at school told me my caregivers don’t love me anymore.
 - o My best friend and I got into a fight and she is not talking to me anymore.
 - o An older student called me stupid and ugly today.
 - o My mother missed our visit today.
 - o My father was supposed to call yesterday and he didn’t.

Tool: Use Reinforcement

- General instructions
 - o Begin role play sitting or standing far enough away so the caregiver has to move towards you
 - o You will be engaging in appropriate behavior

- Role Plays
 - **Come home and immediately do your homework (official pre/posttest)**
 - You're making your bed
 - You're setting the table for dinner
 - You made an A on your science project
 - You're folding your clothes
 - You're doing your homework
 - You're helping your younger sibling with his homework.
 - Your reading teacher said that you did a great job reading in front of the class today.
 - You made the baseball team.
 - You finished your homework assignment two days before it is due.
 - You're loading the dishwasher.
 - You're mowing the lawn.
 - You're taking out the trash.

Pivot

- General instructions
 - If doing individual child scenario, start w/ junk behavior, then eventually stop and engage in the appropriate behavior
 - You roll your eyes, slam your hand on the table, and then slowly get up.
 - Walk very slowly, shuffling your feet, engage in the requested task. Say something like: "How come I always have to (do the damned task)?"
 - Emit some more junk, but pause occasionally, allowing the caregiver time to speak.
 - Once task is done, slam the door, pick up your magazine, and say, "There, are you happy now?"
 - If doing two child scenario, one child immediately engage in the appropriate behavior (for at least 15s or until the caregiver praises you), while the second child engages in junk behavior, then eventually stops and engages in appropriate behavior
- Role Plays
 - **Ask one child to take out the garbage (official pre/posttest)**
 - Ask one child to go make their bed
 - Ask both children to sit for dinner (one plays with food)
 - Ask one child to do their homework
 - Asking two children to do the dishes (one plays with water)
 - Ask two children to put on their coat to go get ready to go to the store (one flops down on the chair and complains)
 - Ask one child to clean dishes off table (child complains)
 - Ask two children to help you bring the groceries in from the car (one stomps around the kitchen and refuses)
 - Ask one child to pick up their toys in the living room
 - Ask two children to turn the TV off and get ready for bed (one child refuses to turn off TV)

Redirect-Use Reinforcement

- General instructions
 - You will engage in a semi-dangerous problem behavior, something that will need to be redirected
 - Generally the caregiver will walk in or suddenly notice the child engaging in this behavior
 - If you are redirected, give a brief bit of whining or crying and briefly resist by pulling against the caregiver, falling to the floor and stomping feet, saying “I can do it”, etc., but not for more than three to five seconds.
 - If there is no intervention, continue to engage in the behavior.
 - If the caregiver redirects you to an alternate behavior, engage in the alternate behavior
 - If there is no redirection, eventually go engage in an appropriate behavior so the caregiver has a chance to provide praise
- Role Plays
 - **You see your 3 YO throw small plastic toy in bassinet with your 2 month old (official pre/posttest)**
 - You walk into the kitchen and notice that your 9 YO has a kitchen knife in his hand and he is trying to open a new CD
 - You are grocery shopping with your 6 YO, he starts to tip cereal boxes off the shelf
 - Your 3 YO keeps taking off her arm tubes when she goes into the pool; you want her to wear them before she can go in
 - You see your 12 YO sneaking into the pantry and grabbing some cookies before dinner
 - You are at the gas station; 9 YO grabs random candy bars and is asking you if he can have them.
 - Your 6 YO is about to chase your dog across the street
 - Your 7 YO is digging in her mom’s makeup bag
 - 4 YO drawing on the wall with crayons
 - 14 YO isn’t supposed to be talking on the phone, but you see her reach for it