University of South Florida
Scholar Commons

Graduate Theses and Dissertations   Graduate School

2011

An Evaluation of Booster Training Using Video Modeling with Foster Parents

Anna Katherine Caravello
University of South Florida, acaravel@mail.usf.edu

Follow this and additional works at: http://scholarcommons.usf.edu/etd

Part of the Americana Studies Commons, and the Behavioral Disciplines and Activities Commons

An Evaluation of Booster Training Using Video Modeling with Foster Parents

by

Anna Katherine Caravello

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
Department of Child and Family Studies
College of Behavioral and Community Sciences
University of South Florida

Major Professor: Kimberly Crosland, Ph.D.
Norin Dollard, Ph.D.
Rose Iovannone, Ph.D.

DEDICATION

First and foremost I would like to thank my thesis advisor, Dr. Kimberly Crosland, for all her assistance, guidance, and patience with my thesis. I would like to dedicate my thesis to my fiancé and support system Peter and two beautiful children, Riley and Alexa. And a special thanks to my research assistants, Rachel, Emily, and Victoria. Because of these people my thesis was a success.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

In order for foster parents to be prepared to manage problem behavior and develop a positive relationship with a child in their home, local foster care agencies require these parents to attend parent training classes. Unfortunately, even foster care agencies that offer empirically validated parent training courses are unable to prevent the parents' performance from decreasing over time (Cowart, Iwata, & Poynter, 1984; Forehand & King, 1977; Mueller et al., 2003). However, researchers have created booster training sessions to counteract this issue. Booster training sessions allow participants to attend a brief refresher course on skills they have previously learned. Another intervention that has been successful with skill acquisition is video modeling. Video modeling requires less response effort and is not as time consuming compared to other training methods like didactic teaching. The current study evaluated the effectiveness of booster training sessions using video modeling for foster parents who completed a parent training class that was based on basic behavior analysis principles. Results showed an increase in the participants' skills after they received booster training sessions using video modeling.

INTRODUCTION

Children in foster care often experience traumatic events such as physical abuse, sexual abuse, and neglect (Puddy & Jackson, 2003). These children may experience feelings of hopelessness and fear at a young age (Puddy & Jackson, 2003). Due to these stressors, child welfare agencies need to ensure that children are placed in stable homes with competent foster parents. Leathers (2002) suggested that 33% to 85% of children display emotional and behavior problems while in foster care. High levels of failed placements (Redding, Fried, & Preston, 2000), school failure (Benedict, Zuravin, & Stallings, 1996; McMillen, Auslander, Elze, White & Thompson, 2003), and juvenile delinquency (Pardeck, Murphy, & Fitzwater, 1985) are associated with behavior problems of children in foster care. Boyd and Remy (1978) and Fees et al. (1978) found that effective parent training can reduce the incidence of failed placements and increase the probability of desirable placement outcomes.

The goal of behavioral parent training is to teach parents effective techniques or practices to manage undesirable child behavior and provide a positive learning environment for children in foster care to increase desirable behaviors (Puddy & Jackson, 2003). The application of parent training programs for families in the child welfare system has undergone relatively little examination (Barth et al., 2005). Some parent training curricula that have been evaluated through empirical research have even been

identified as ineffective (Barth et al., 2005). There are a limited number of parent training programs that have been recognized as evidence-based practice, all of which have incorporated principles of behavior analysis into their programs (Herschell, Calzada, Eyberg, & McNeil, 2002b; Linares, Montalto, Li, & Oza, 2006). Parent training programs that are behaviorally based have been shown to be highly effective in producing changes in parenting behavior that lead to desired changes in child behavior (Barker, 1989; Hawkins, Meadowcroft, Trout, & Luster, 1985; Kraus & Fredericks, 1987).

One program in particular that was found to be successful was the Behavior Analysis Services Program (BASP) (Stoutimore, Williams, Neff, & Foster, 2008)[1]. The BASP focused on behaviorally based training and technical assistance for caregivers in the child welfare system throughout the state of Florida. The BASP worked with Florida's Department of Children and Families (DCF) and its Community-based Care Initiative, which provides community-based privatized child welfare services for children who have been abused, neglected, and/or abandoned. A curriculum titled, "The Tools for Positive Behavior Change" was developed and taught by behavior analysts within the BASP. The curriculum was based on the principles of Applied Behavior Analysis (ABA) and the book "The Power of Positive Parenting" (Latham, 1994). The curriculum, composed of ABA principles with a combination of performance-based classroom and on-site training, was intended to be taught to foster caregivers within the child welfare system and has since been applied to different types of caregivers and staff (i.e. biological parents, caseworkers, and direct care staff at group facilities).

[1] The thirty hour course is taught in ten 3-hour weekly sessions, teaches nine task analyzed tools and provides on-site training. The fifteen hour course is taught in five 3-hour weekly sessions and teaches seven task analyzed tools (Stoutimore et al., 2008).

The effectiveness of the "Tools for Positive Behavior Change" has been assessed with a variety of caregiver populations: foster parents, staff of residential settings and agencies, adoptive parents, biological parents, and relatives of foster children (Crosland, Cigales et al., 2008; Crosland, Dunlap et al., 2008; Van Camp, Montgomery et al., 2008; Van Camp, Vollmer et al., 2008). Researchers indicated that the "Tools for Positive Behavior Change" curriculum improved performance, decreased the use of restrictive procedures, increased positive interactions, improved parent-child interactions, and decreased child problem behaviors (Crosland, Cigales et al., 2008; Crosland, Dunlap et al., 2008; Van Camp, Montgomery et al., 2008).

When researchers develop interventions, it is important to assess the effectiveness of the program, however, researchers as well as practitioners, should also program and assess for the generalization and maintenance of skills (Stokes & Baer, 1979). Researchers have reported that there were few studies that assessed trained parenting skills beyond a few months after implementation (Van Camp, Montgomery et al., 2008). Macdonald and Turner (2005) stated that trained skills declined after extended amounts of time and had no differential effects on child problem behavior and placement stability. Other studies have reported similar findings (Linares et al., 2006). Within the behavior analysis literature the maintenance of behavioral parent training skills has been assessed for up to three months post training (Cowart et al., 1984; Forehand & King, 1977; Mueller et al., 2003) which showed decreases in skills.

Although the literature has demonstrated that there are not lasting effects of training during follow-up, few studies have used booster training in response to a lack of maintenance as assessed during follow-up with particular populations and curriculum

3

(McDonald & Budd, 1983; Van Camp, Montgomery et al., 2008; Miller & Crosland, 2008). Booster trainings have been used to address the lack of skill acquisition during initial training or during observations immediately after training as soon as parent performance decreases (Marcus, Swanson, & Vollmer, 2001). Van Camp, Montgomery, et al. (2008) conducted a study assessing the maintenance of parenting skills for foster parents that had completed the thirty hour "Tools for Positive Behavior Change" training. Researchers examined whether booster training sessions would raise caregiver performance. Participants were assessed via role-play scenarios on the first and last days of the thirty hour course and again immediately before and after the booster training. Results suggested that, on average, skill levels decreased within 6 to 35.5 months after the completion of training; however scores did return to posttraining levels or higher following booster training. The authors did note that there was individual variability. This study as well as others (Marcus et al., 2001) suggests that brief refresher sessions are effective in improving parenting skills when initial training has either failed to produce the desired outcomes or when parent performance decreased following a period of accurate responding.

Although parent training programs can be effective in improving parenting skills which can lead to desirable behavior change on the part of the child, these training sessions can be time consuming and sometimes costly for parents. There are several advantages of booster training that can be beneficial in the applied setting. First and foremost the participants receive a refresher course on the skills they were taught during the initial training. Second, because the trainers are running preassessments, the trainers can identify where the participants need the most assistance, which will benefit the

participants. For example in the "Tools for Positive Behavior Change" curriculum participants are assessed prior to the training, if the participant scores low on the skill Use Reinforcement during their preassessment, the trainer can identify the steps that were missed and review those steps with participants during their booster training session. Third, booster training sessions are less time consuming as the participants may only need to attend once or twice every three to six months to maintain the skills they were taught versus once per week for 5 to 10 weeks for the initial training. There is also less preparation work or response effort on the part of the trainers (i.e., preparing assessments and a brief review of the skills versus preparing assessments, power points of all the skills, preparing and grading homework, preparing group activities, and rehearsing that would need to be done for an initial training).

Another intervention component that could be incorporated into a booster training that would offer several training benefits is video modeling (Krantz, MacDuff, Wadstrom, & McClannahan, 1991). With video modeling the trainer would solely need to be present for setting the video up and conducting assessments. The participant would simply need to watch the video versus participating in a group class and completing homework as is typical in standard initial trainings. Video modeling can efficiently display numerous examples of stimulus and response variations which increases the likelihood of generalization (Miltenberger, 2008). Video role-play scenarios have been used successfully in previous studies to train observers in assessing the integrity measures of interventions and for skill acquisition (Iwata et al., 2000; Phaneuf & McIntyre, 2007).

Haring, Kennedy, Adams, and Pitts-Conway (1987) tested the effectiveness of video modeling to promote generalization of purchasing skills across community settings.

The participants, three young adults diagnosis with autism, were trained to purchase items. Training was conducted at first in one setting which failed to produce generalization. The experimenters then conducted generalization training, which consisted of watching videotapes of models who purchased items in probe settings and answering questions about the models' responses was then introduced. Results indicated that the use of the video modeling procedure, in combination with shopping training in one natural environment, were effective in promoting generalization of purchasing skills. Authors stated that the "videotape modeling procedure resulted in increase independent functioning and social responding for all three students" (Haring et al., 1987).

In 1991, Neef, Trachtenberg, Loeb, and Sterner evaluated video-based training of respite care providers in a presentation format (viewing the videotapes alone, with a partner, and with structured group training). The instructional videotape was developed for each of the skill modules of a curriculum (Neef & Parrish, 1989). The format for each module consisted of behavioral objectives, introduction, management strategies, examples of and rationale for the strategies, a quiz, and a review. Experimenters conducted a generalization probe (upon completion of training) in an actual respite care situation as well as maintenance probes one to six months after completion of training. Correct responding generalized to respite care situations involving a developmentally disabled child. Authors commented that in most cases the acquired skills were maintained for up to six months.

In 2009, Catania, Almedia, Liu-Constant, and DiGennaro Reed assessed the effectiveness of video modeling on the accuracy of discrete-trial instruction with three new direct-care staff. Experimenters collected data on the percentage of accuracy in

completing a discrete-trial teaching session using a multiple baseline design across participants. During the video modeling condition, performance in accuracy increased up to 98%. Participant performance also remained at high levels during maintenance and generalization probes. The results of the studies described have shown that video modeling can be an effective technique to train skills.

There is no known literature evaluating video modeling for booster training sessions to increase the maintenance of caregiver skills. This study will add to the literature by identifying video modeling as an intervention for booster training that can be used to maintain skills for foster parents that had been previously trained. Video-modeling may be more cost effective and require fewer trainers. The purpose of the current study was to evaluate the maintenance of parenting skills with foster parents who had completed a behavioral based parent training curriculum and provide booster training using video modeling to increase skills.

METHOD

Participants and Setting

This study had three participants, two females, Alexa, 36, and Anna, 34; and one male, Peter, 36. Anna and Peter were a married couple. Pseudo names were used to ensure privacy of the participants. All participants were licensed foster parents currently in Florida's foster care system and had at least one foster child in the home at the time of this study. The participants had completed the 15 hour "Tools for Positive Behavior Change" course at some point in the past 4 to 8 months. Alexa completed the course 8 months prior to receiving booster training session. Anna and Peter completed the course 4 months prior to receiving booster training session.

The study was conducted in two locations, a Community Based Care Agency location (e.g. foster care agency) and home setting. The study with the first participant, Alexa, was conducted in two visits at the Community Based Care Agency location. During the first visit the researcher conducted the preassessments in a small visitation room. This room consisted of two small couches, one table, and a variety of toys. During the second visit the researcher conducted the booster training in a large meeting room that consisted of one large table, several chairs, two laptops, and one printer.

The second location of the study was in the participants' home, Peter and Anna. The researcher conducted the study with each participant separately, Peter was located in the family living room and Anna was located in the guest bedroom. The family living

room was connected to the kitchen. This room consisted of a large couch, and dining room table. The guest bedroom consisted of a twin bed and three chairs.

Initial Training

The participants had attended and completed the 15-hr "Tools for Positive Behavior Change" course (Eckerd Youth Alternatives, 2010). The purpose of this course was to teach caregivers how to increase desirable behavior and decrease problem behavior in children. The course was taught in three hour classes, once per week for five weeks, and was presented by the behavior analysts employed by a local community-based care agency (child welfare agency). The participants were taught five tools throughout the course. The tools were the following: Stay Close, Use Reinforcement, Setting Expectations, Redirect, and Pivot. At the beginning of the course, each participant received a copy of the book, "The Power of Positive Parenting" (Latham, 1994). To identify the skills of each participant, the trainers conducted pre- and post role-play based assessments. Each week the trainers taught a tool that was broken down into task analyzed steps (See Appendix B for a task analysis of the steps for each of the tools). The trainers presented the material through didactic instruction in a power point presentation format. The trainers identified and defined the tool that was taught for each session at the beginning of class. During the class the trainers presented role-play scenarios that demonstrated a typical situation in the home and another situation in which the tool was implemented. The trainers also conducted group activities with the participants. For example, during one group activity the trainers had each participant practice the step from Stay Close called "providing an empathy statement". The trainer would say "I made the

basketball team!" then the participant provided an empathy statement such as "You seem really excited about that!". At the end of each class, the trainers assessed the tool that was taught in class. The trainers began by presenting a novel role-play scenario to the participants then the participants responded using the steps of the tool. Trainers recorded which steps were completed, missed, or not applicable. Not applicable would be marked if the trainer did not provide an opportunity for the participants to engage in that step. Trainers provided feedback in the form of praise and corrective feedback was provided based on the participants' score. In addition to the role-play scenarios and group activities, the participants were assigned homework in the form of worksheets and reading assignments from "The Power of Positive Parenting" book (Latham, 1994). The worksheets consisted of the participants practicing the tools in their home and describing their experience with each step, providing examples of steps from the tools (e.g. providing a benefit if the child asks why during Setting Expectations), and identifying each tool that is appropriate for different scenarios.

Initial Training Pre- and Postassessments

The skill assessments for the 15-hr "Tools for Positive Behavior Change" course were completed prior to this study. Trainers conducted these assessments during the first and last weeks of the initial 15 hour class, to assess the skill level prior to class and after participants were taught the tools. During the assessments, the presentation of the role-play scenarios order was random. The trainers presented five role-plays scenarios (one for each tool taught), in which the trainer played the role of the child and the participants played the role of the caregiver. The trainer described the role-play scenario to the

participant. This included a description of the trainer's role, the participant's role in each scenario, and the description of each scenario. Afterwards, the trainer answered any questions the participant had. The trainer then informed the participant that the role-play scenario would begin when the trainer said "Start". When the trainer collected the data that was needed the trainer would say "Stop" and the role-play ended. The trainer then moved on to the next scenario. For a more detailed description of the trainer's guide and each scenario see Appendix A.

Booster Training

The booster training sessions consisted of the participants watching a three part video. There were two trainers with each participant in a room during the booster training. During booster training the participants watched a video on the first two tools, Stay Close and Use Reinforcement then completed postassessments for Stay Close and Use Reinforcement and preassessments for Redirect, Pivot, and Setting Expectations. The participants then watched the video for the next two tools, Redirect and Pivot, and then completed postassessments for Redirect, Pivot, Stay Close, and Reinforcement and preassessments for Setting Expectations. The participants then watched the last tool Setting Expectations and completed postassessments for all of the tools.

booster training video. The video was a modified version of the "Parenting Tools For Positive Behavior Change" video (Colbert, 2005). The video depicted a variety of role-play scenarios for each step of each tool. The video for Stay Close was 6 minutes in duration, the Use Reinforcement video was 1 minute and 30 seconds in duration, the

11

Pivot video was 1 minute and 20 seconds in duration, the Redirect video was 1 minute and 20 seconds in duration, and the Setting Expectations video was 9 minutes in duration. The video showed all tools taught in the initial training. There were three example role-play scenarios for each step of the tools. The first example consisted of the participants watching a step by step demonstration of a tool, meaning that as the participant watched the role-play scenario, the role-play scenario paused and briefly showed the name of the step across the screen that was being implementing during the scenario. During the second example the participants watched the same role-play scenario without the step by step demonstration. The participants then watched a third example of a novel role-play scenario without the step by step demonstration.

Alexa's booster training was conducted in two visits. The first visit of the booster training session was conducted on a week day and lasted 45 minutes. The second visit of booster training was conducted on a weekend and lasted two and half hours. Peter and Anna's booster training sessions were conducted in one visit on a week day and lasted two and half hours each.

Pre and Postbooster Training Assessments

The trainer began the prebooster training assessment by informing the participant that they would be participating in several role-play scenarios. This included a description of the trainer's role, the participant's role in each scenario, and the description of each scenario. Afterwards, the trainer answered any questions the participant had then informed the participant that the role-play scenario would begin when the trainer said "Start". When the trainer had collected the data that was needed the trainer said "Stop"

and the role-play ended. The trainer then moved on to the next scenario.

Postassessments occurred as described in the booster training section above (i.e., when the participants completed the booster training session on two tools (with the exception of the last session which was one tool). The trainer conducted postbooster training assessments on all of the tools. It is important to note that the pre and postbooster training assessment scenarios were slightly different than the pre and post scenarios previously used from the initial training (For a detailed description of pre and postbooster training role-plays, see Appendix C). Data were collected on the participants' behavior, which were scored as accuracy of the steps completed of each tool by using the same checklists from the initial training that include task analyzed steps of the five tools taught in the booster training. These steps, listed in Appendix A, were scored for each participant for each skill. For each step, the observer scored whether (a) the participants correctly demonstrated the step or (b) did not correctly demonstrate the step or (c) Not Applicable (N/A) which is scored if the trainer did not provide an opportunity for the participants to engage in that step. For example, if the trainer did not provide an opportunity for the participant to get physically close (i.e. table in between them), the trainer counted this step as Not Applicable. This occurred 7 times (less than 5% of assessments) during data collection out of all the assessments conducted with the participants. Each tool was scored by the percentage of steps performed correctly divided by the total number of steps for the skill, then multiplied by 100. See Appendix B for task analyzed data collection sheets for each tool.

Interobserver Agreement

A second observer simultaneously and independently observed and scored for 90% of the pre and postbooster training role-play assessments. The second observer was either a Board Certified Behavior Analyst (BCBA) or an ABA master's level student that was trained in the curriculum and had experience conducting and scoring role-play scenarios. The second observer's scores were compared to the primary observer's scores in order to calculate interobserver agreement (IOA). IOA was calculated by the two observers' checklists being compared to determine agreements and disagreements. For example, if both observers scored that the participants completed the step correctly; this was counted as an agreement. Likewise, if the observers both agreed that a step was not completed; the score was counted as an agreement. If one observer scored that a step was completed and the other observer scored that the step was not completed, this was counted as a disagreement. Agreements and disagreements were totaled for each role-play and then divided by the total number of steps possible for the role-plays. Interobserver agreement scores were calculated separately for each tool at each assessment point using the formula (number agreements/ number agreements+disagreements) multiplied by 100.

The overall IOA average score was 88%. For Alexa, IOA for preassessments was 78% and 90% for postassessments. For Peter, IOA for preassessments was 93% and 90% for postassessments. For Anna, IOA for preassessments was 85% and 89% for postassessments.

Experimental Design

There were two designs used within this study. The first design was a modified phase change ABAB design similar to that used by Barlow, Hayes, and Nelson (1984). In these designs, time passing without training was considered a variable connected to treatment. A true reversal design cannot be conducted because it is not possible to remove the skills that were already taught in the initial training in order for it to be a true reversal design. During phase A, the trainers conducted preassessments (prior to the 15-hour training). The B phase that followed was the first posttraining phase (following the initial 15-hour training). The second A phase contained assessments which began approximately 4 to 8 months after the initial training and just prior to the booster training. The degree of similarity between this phase and the first pretraining and posttraining phases indicated how well the skills had maintained (Van Camp, Vollmer et al., 2008). It was hypothesized and confirmed that the time between the last treatment phase and the booster training resulted in changes in skill levels for most of the participants (i.e. a decrease in the implementation of the independent variable). Therefore, the booster training was implemented as the second intervention phase (Phase B). Additionally, a concurrent multiple baseline design across tools was employed throughout the booster training phase of this study (e.g. last two phases).

Social Validity

Following the study, each participant completed a social validity questionnaire. The purpose of the social validity measure was to learn how valuable interventions were to those expected to benefit from those interventions (Baer, Wolf, & Risley, 1968) so that

the results might inform the current researcher and others of important intervention components, how to improve assessments and interventions, and issues related to the feasibility of interventions. This particular questionnaire included three statements rated on a Likert scale (1-5): 1) I felt like the booster training helped me remember again and/or maintain skills which I had originally acquired during the initial training and; 2) I felt like the video was useful with teaching me the steps; 3) After the booster training, I felt like I was better prepared to handle the behaviors of children. It then offered two open-ended questions: 1) What did you like about the booster training? and; 2) Is there anything that you would have changed about the study?

RESULTS

The results displayed an increase from preinitial training to postinitial training for two out of the three participants across all tools. Peter's scores from preinitial training to postinitial training either maintained or decreased. The results from the booster training demonstrated an increase from prebooster training to postbooster training for all three participants across all of the tools (see Figures 1-3).

Alexa's scores from the tool Stay Close during the postbooster training demonstrated an increasing trend then stabilized at 100% followed by a slight decrease to 88%. Alexa's scores for Pivot and Redirect during the prebooster training assessment were variable. Her initial score for Pivot was 40% but then her scores dramatically increased to 100% for the next two assessments then stabilized at 80% for her last two assessments. During Redirect Alexa's initial scores were 60% then decreased to 30% then increased to 100% followed by a decreasing trend. Alexa's scores during postbooster training for Redirect were also on a decreasing trend but then increased to 100 %. During prebooster training for Setting Expectations Alexa's scores demonstrated an increasing trend then after the fourth assessment a decreasing trend was noted. Alexa's scores during postbooster training for Setting Expectations were on a decreasing trend then increased from 75% to 100%. See Figure 1 for Alexa's individual scores across tools. Alexa's average scores from prebooster training to postbooster training

demonstrated improvement across all tools (range 87% to 100%). See Table 1 for Alexa's average scores from prebooster training to postbooster training.

Peter's scores during prebooster training for Use Reinforcement demonstrated an increasing trend then decreased from 100% to 70%. Peter's scores during postbooster training for Use Reinforcement demonstrated some variability with the initial scores being 100% then decreasing to 50% then increasing back to 100% then stabilized at 70%. See Figure 2 for Peter's individual score across tools. Peter's average scores demonstrated that he improved more on Pivot, Redirect, and Setting Expectations than Stay Close and Use Reinforcement. Peter's lowest score was on the tool Stay Close. Peter demonstrated the most improvement from prebooster training to postbooster training on the tool Pivot (range 0% to 100%). See Table 1 for Peter's average scores from prebooster training to postbooster training.

Anna's scores during postbooster training for the tool Stay Close demonstrated variability. Anna's scores varied between 75% and 50% for the first four assessments than were stabilized at 63%. During prebooster training for the tool Use Reinforcement Anna's initial score was 50% then increased and was stable at 100%. During postbooster training for the tool, Pivot, Anna's scores were stable at 100% with the exception of the second assessment, Anna's score decreased to 60%. During prebooster training for the tools, Redirect and Setting Expectations, the scores were on an increasing trend. During Redirect after the fifth assessment scores shifted to a decreasing trend. During prebooster training for Setting Expectations Anna's scores were on an increasing trend but her scores did decrease but remained high between 83% and 92%. See Figure 3 for Anna's individual scores across tools. Anna's postbooster training average scores were extremely

high (range 90% to 100%) for all the tools except for the tool, Stay Close. Anna's average score for Stay Close was extremely low, 63%. See Table 1 for Anna's average scores from prebooster training to postbooster training.

Social Validity Results

The overall results from the social validity assessments were extremely high and positive. Alexa's results were all strongly agreed for the first three statements on the assessments. See Social Validity section for a description of the three statements. Alexa stated that she enjoyed the varied role-plays and the videos were informative in reminding her of the steps she had forgotten. Peter's results were also either agreed or strongly agreed for the first three statements. Peter stated that the video and role-plays were beneficial. Anna was sent the social validity assessment but did not return it. See Table 2 each participant's average scores on the social validity assessment.
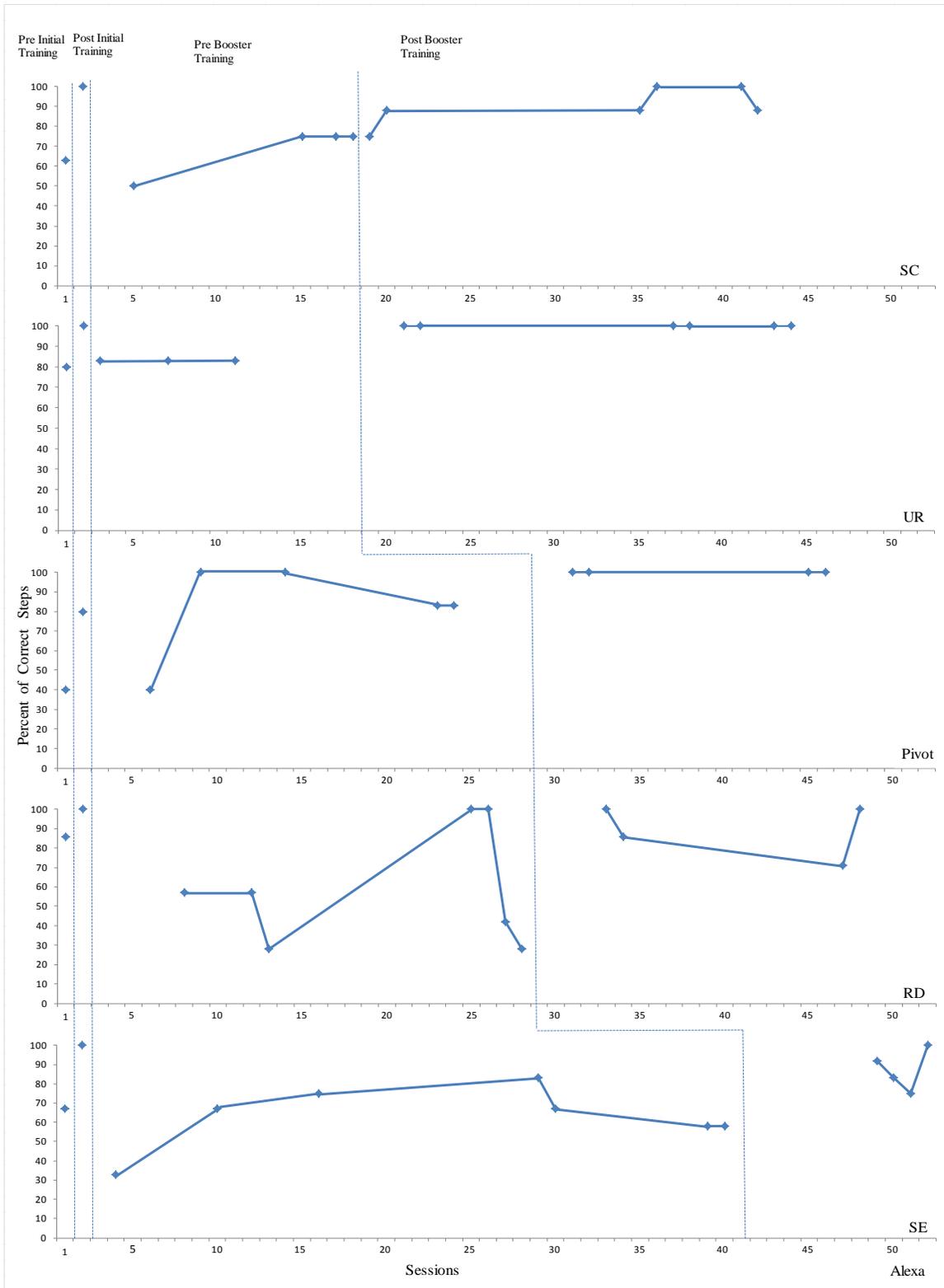
Figure 1. Alexa Graph. Above is Alexa's individual score of the percentage of corrects steps for pre- and post initial training and prebooster training and postbooster training across tools. SC=Stay Close, UR=Use Reinforcement, SE=Setting Expectations

Figure 2. Peter Graph. Above is Peter's individual score of the percentage of corrects steps for pre- and postinitial training and prebooster training and postbooster training across tools. SC=Stay Close, UR=Use Reinforcement, RD=Redirect, SE=Setting Expectations
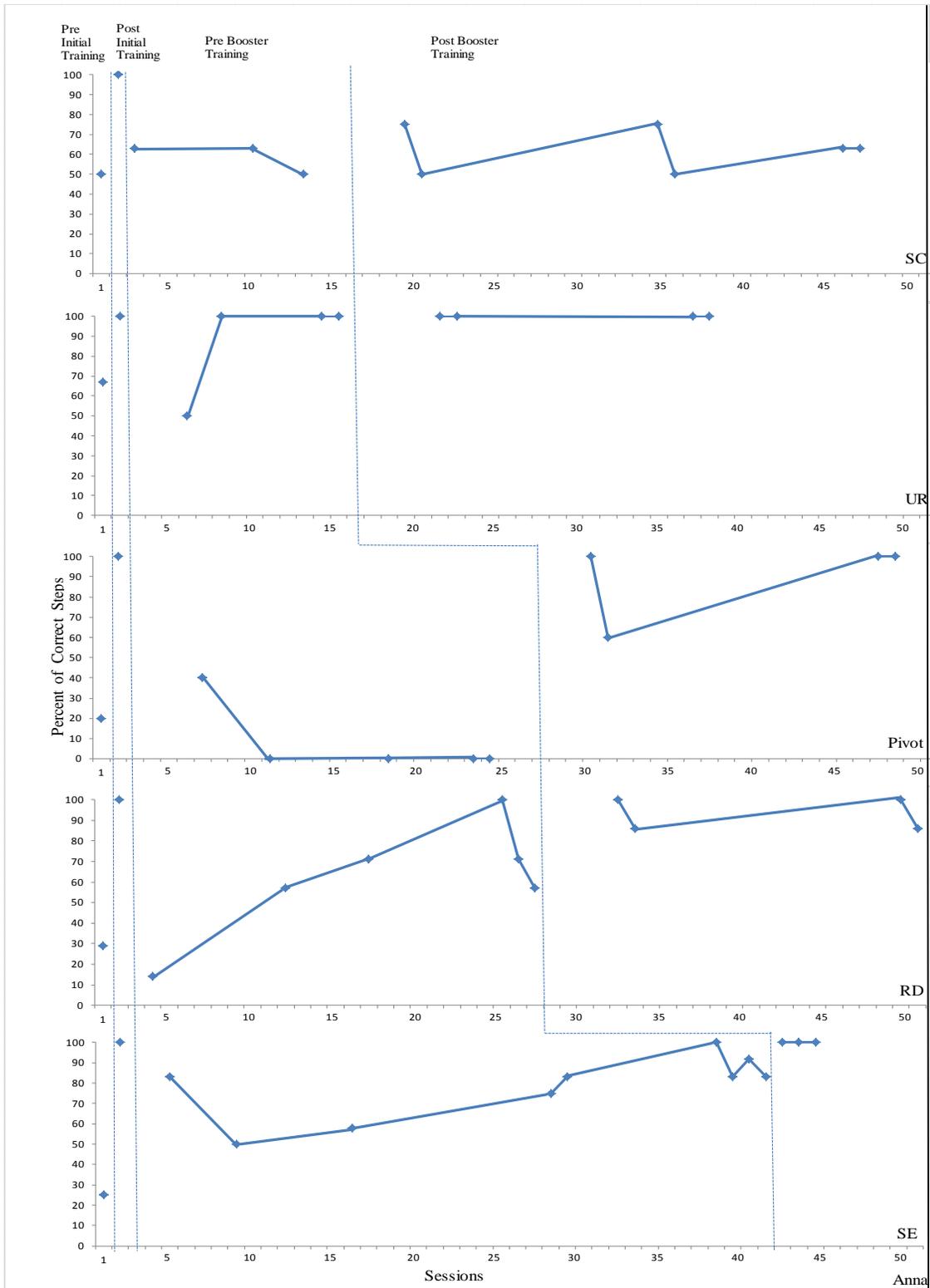
Figure 3. Anna Graph. Above is Anna's individual score for pre- and postinitial training and prebooster training and postbooster training across tools. SC=Stay Close, UR=Use Reinforcement, RD=Redirect, SE=Setting Expectations
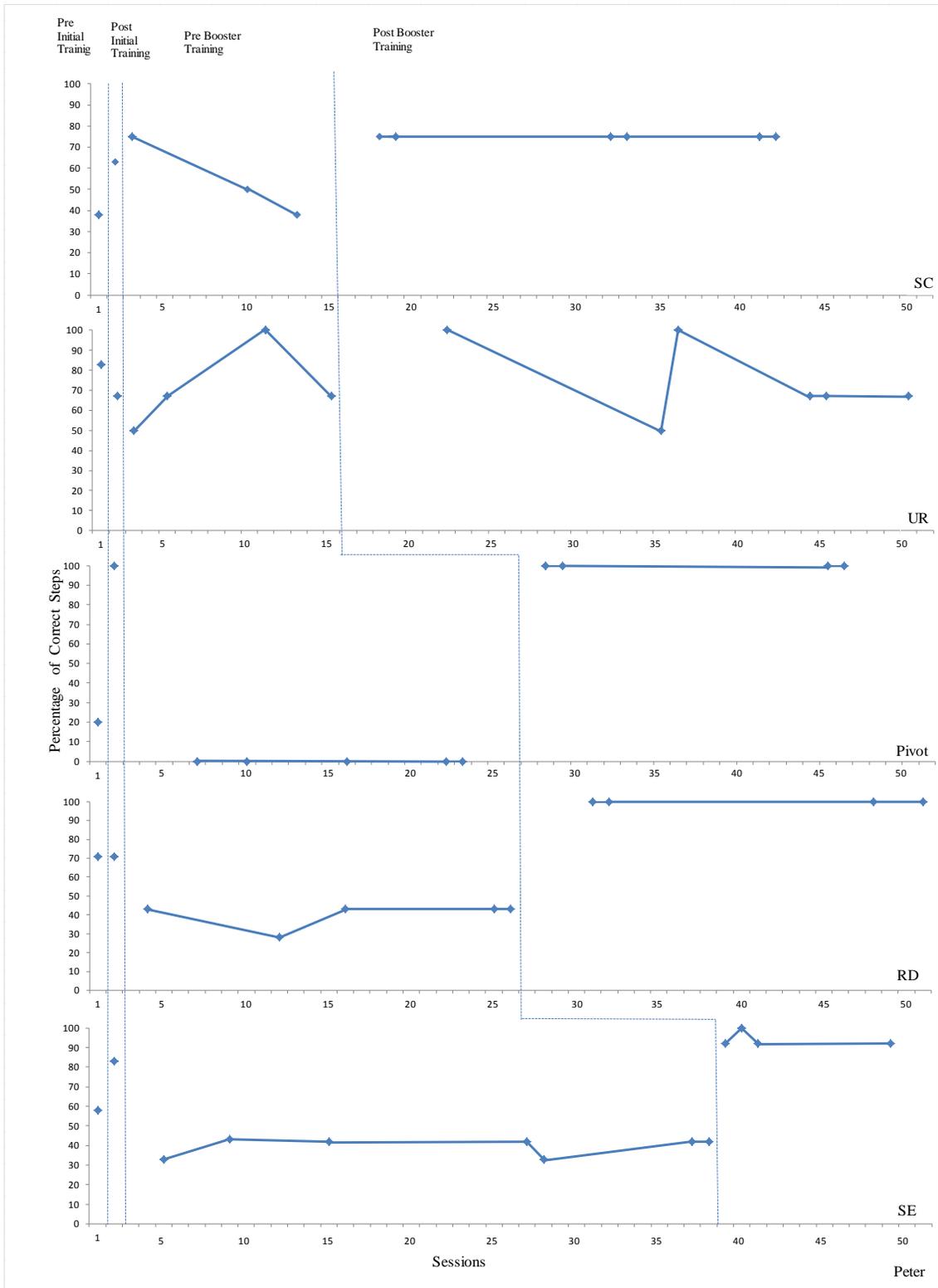
22

Table 1

Participants Average Scores Across Tools from Pre to Post Booster Training

Participant	Phase	SC	UR	P	R	SE
Alexa	Pre Booster	69	83	81	59	63
	Post Booster	90	100	100	89	87
Peter	Pre Booster	54	71	0	40	40
	Post Booster	75	79	100	100	94
Anna	Pre Booster	59	88	8	62	79
	Post Booster	63	100	90	93	100

Note. This table shows each participant's average score for each tool from pre booster training to post booster training. SC=Stay Close, UR=Use Reinforcement, P=Pivot, R=Redirect, SE=Setting Expectations

Table 2

Average Scores for Social Validity Assessment

Participant	Average Score
Alexa	5
Peter	4.7

Note. Above is each participant's average score for the questions that used Likert scale in the social validity assessment. 1=Strongly Disagreed, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

DISCUSSION

The main objective of this study was to determine if a video modeling booster training would be effective in improving the performance of three foster parents on basic behavioral tools. The current study demonstrated an increase in the skills of the foster parents after they received the video modeling booster training session. Video modeling improved the skills of the foster parents back to the same or higher levels from the initial posttraining assessments. This is encouraging as the video portion of the study only lasted 20 minutes in duration compared to typical initial or booster training sessions that can last from several hours to multiple days. Therefore the response effort on the part of the caregivers is minimal as foster parents can watch the video from the comfort of their home in a short time period. Typically foster parents would be required to drive to a class, be in class for several hours, find a babysitter if necessary, and spend money on gas and food.

The video also requires less response effort and little expertise on the part of the trainer as well. The trainer would solely need to be present for setting the video up and conducting assessments which is a dramatic decrease in effort compared to the typical class of lecturing, preparing and grading homework, answering questions, etc.

It was encouraging that the participants' answers to the open-ended questions were positive considering the extended number of role plays required for the study. Anna stated that she enjoyed the variety of role play scenarios and that the videos were

informative in remembering some the steps she had forgotten. Peter stated that the second half of the booster training session was beneficial, which including watching the videos and participating in the role plays.

The results of this study are not without limitations. Although the intervention was shown to be effective, future research should consider including a wider variety of participants (such as biological parents and staff members at group facilities) as this study only included licensed foster parents. Therefore, researchers could see if the intervention was effective within a larger population group. Researchers may also want to conduct follow up assessments several weeks or months after the participants receive the booster training both to determine if the skills maintain and at what point decreases in skills levels are noted. The participants in the current study received the initial training from 4 to 8 months prior to the booster training. It is not known at what point decreases in skills start to occur and at what point a booster training might be most effective in maintaining skills. It also appeared that not all skills were lost prior to the booster training (i.e., Anna implemented Use Reinforcement at 100% during the prebooster training assessments). It might be worthwhile to determine if certain skills or steps are more difficult and more likely to be forgotten over time.

This study involved only role-play scenarios with a researcher. It is not known whether the participants were able to generalize the skills to their own children in the home environment. Future studies should examine the use of the skills in natural settings with children. The role play scenarios were the same from prebooster training assessments to postbooster training assessments in order to control for the type and difficulty of the scenarios across phases. However, participants may have remembered

the scenarios. The participants commented several times throughout the study "Didn't we do this scenario already?" It is a possibility that since the role play scenarios were the same from the prebooster training assessments to the postbooster training assessments that the participants memorized the scenarios but did not necessarily know the steps of the tools.

It might be useful for future research to better assess the quality of the role play scenarios. Even though Peter had positive results from the social validity assessment he stated several times throughout the booster training session that he "didn't feel like the scenarios applied to real life." Peter stated that this made it difficult to implement steps of the tools because he didn't believe that he would ever experience these scenarios. Currently, Peter and Anna have a toddler in the home. Many of the role play scenarios included a wide variety of ages from 2 to 17. To avoid this issue, future researchers could tailor the role play scenarios of each tool to the participants' situation. For example, if the participants have a 5 year old in the home the trainers could create role play scenarios that included only younger children.

The current study's intervention of video modeling was able to provide an improvement in the participants' skills of the tools. Future researchers should conduct follow up assessments to understand if generalization occurs in the foster parents' home and should also conduct the video modeling with more participants to order to demonstrate this intervention is effective with a variety of people. Future studies should promote the advantages of the video modeling training including less response effort on the participants and the trainers.

REFERENCES CITED

Baer, D.M., Wolf, M.M., & Risley, T.R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Anaylsis,1,* 91–97.

Barker, J.N. (1989). Therapeutic foster parent: Professionally or emotionally involved parent? *Child & Youth Services*, *12,* 149-157.

Barlow, D.H., Hayes, S.C., & Nelson, R.O. (1984). *The Scientist Practitioner: Research and Accountability in Clinical and Educational Settings*, New York: Pergamon.

Barth, R.P., Landsverk, J., Chamberlain, P., Reid, J.B., Rolls, J.A., Hulburt, M.S., et al. (2005). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*, *15*(5), 353-371.

Benedict, M.I., Zuravin, S., & Stallings, R.Y. (1996). Adult functioning of children who lived in kin versus nonrelative family foster homes. *Child Welfare*, *75,* 529-549.

Boyd, L.H., & Remy, L.L. (1979). Foster parents who stay licensed and the role of training. *Journal of Social Service Research, 2,* 373-387.

Catania, C.N., Almeida, D., Liu–Constant, B. & DiGennaro Reed, F.D. (2009). Video modeling to train staff to implement discrete-trial instruction. *Journal of Applied Behavior Analysis, 42,* 387-392.

Colbert, B. (2005). Parenting Tools for Positive Behavior Change. *Heartland for Children,* Behavior Analysis Services Program, District 14.

Cowart, J.D., Iwata, B.A., & Poynter, H. (1984). Generalization and maintenance in training parents of the mentally retarded. *Applied Research in Mental Retardation, 5,* 233-244.

Crosland, K.A., Cigales, M., Dunlap, G., Neff, B., Clark, H.B., Giddings, T., Blanco, A. (2008). Using staff training to decrease the use of restrictive procedures at two facilities for foster care children. *Research on Social Work Practice*, *18*(5), 401-409.

Crosland, K.A., Dunlap, G., Sagner, W., Neff, B., Wilcox, C., Blanco, A., Giddings, T. (2008). The effects of staff training on the types of interactions observed at two group homes for foster care children. *Research on Social Work Practice*, *18*(5), 410-428.

Eckerd Community Alternatives (2010). *Tools for Positive Behavior Change 15 hour Curriculum*. Behavior Analysis Department, Largo, Florida.

Fees, B.S., Stockdale, D.F., Crase, S.J., Riggins-Caspers, K., Yates, A.M., Lekies, K.S., & Gillis, A.R. (1978). Satisfaction with foster parent training: Assessment one year after training. *Children and Youth Services Review*, 20, 347-363.

Forehand, R., & King, H.E. (1977). Noncompliant children: Effects of parent training on behavior and attitude change. *Behavior Modification*, *1*, 93-108.

Haring, T.G., Kennedy, C.H., Adams, M.J., & Pitts-Conway, V. (1987) Teaching generalization of purchasing skills across community settings to autistic youth using videotape modeling. *Journal Applied Behavior Analysis, 20*, 89–96.

Hawkins, R.P., Meadowcroft, P., Trout, B.A., & Luster, W.C. (1985). Foster family-based treatment. *Journal of Clinical Child Psychology, 14*, 220-229.

Herschell, A.D., Calzada, E.J., Eyberg, S.M., & McNeil, C.B. (2002b). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice*, *9*, 9-16.

Iwata, B. A., Wallace, M. D., Kahng, S., Lindberg, J.S., Roscoe, E. M., Conners, J., Hanley, G.P.,Thompson, R. H., & Worsdell, A. S. (2000). Skill acquisition in the implementation of functional analysis methodology. *Journal of Applied Behavior Analysis, 33,* 181–194.

Kraus, D., & Fredericks, H.D. (1987). A specialized foster parent training program for youth with severe behavior disorders and mild handicaps. In C.M. Nelson (Ed.), *Severe behavior disorders of children and youth* (pp. 70-81). Boston, MA: College-Hill Press/Little, Brown & Co.

Krantz, P. J., MacDuff, G. S., Wadstrom, O., & McClannahan, L. E. (1991). Using video with developmentally disabled learners. In P. W. Dowrick (Ed.), *A practical guide to using video in the behavioral sciences* (pp. 256–266). New York: Wiley.

Latham, G. I. (1994). The Power of Positive Parenting. North Logan, UT: P & T Ink.

Leathers, S.J. (2002). Foster children's behavioral disturbance and detachment from caregivers and community institutions. *Children and Youth Services Review*, *24*, 239-268.

Linares, L.O., Montalto, D., Li, M., & Oza, V.S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology*, *74*, 32-41.

Macdonald, G. & Turner, W. (2005). An experiment in helping foster-carers manage challenging behaviour. *British Journal of Social Work*, 35, 1265-1282.

Marcus, B.A., Swanson, V. & Vollmer, T.R. (2001). Effects of parent training on parent and child behavior using procedures based on functional analyses. *Behavioral Interventions*,*16*, 87-104.

McDonald, M.R. & Budd, K.S. (1983). "Booster shots" following didactic parent training: Effects of follow-up using graphic feedback and instructions. *Behavior Modification*, *7*, 211-223.

McMillen, C., Auslander, W., Elze, D., White, T., & Thompson, R. (2003). Educational experiences and aspirations of older youth in foster care. *Child Welfare*, *82*, 475-496.

Miller, I. (2008). Behavioral skills training with teachers: Maintenance and booster training. (Unpublished master's thesis). University of South Florida, Tampa, Florida.

Miltenberger, R. G. (2008). Behavioral skills training procedures. *In Behavior Modification: Principles and Procedures*. Thomson Higher Education, Belmont, CA, 251-265.

Mueller, M.M., Piazza, C.C., Moore, J.W., Kelley, M.E., Bethke, S.A., Pruette, A.E., et al. (2003). Training parents to implement pediatric feeding protocols. *Journal Applied Behavior Analysis, 36*, 545-562.

Neef, N. A., Trachtenberg, S., Loeb, J., & Sterner, K. (1991). Video-based training of respite care providers: An interactional analysis of presentation format. *Journal of Applied Behavior Analysis, 24,* 473–486.

Neef, N. A., & Parrish, J. M. (1989). Training respite care providers: A model for curriculum design, evaluation, and dissemination. In G. H. S. Singer & L. K. Irvin (Eds.), *Support for caregiving families* (pp. 175-188). Baltimore: Paul H. Brookes.

Pardeck, J.T., Murphy, W.W., & Fitzwater, L. (1985). Profile of the foster child likely to experience unstable care: A re-examination. *Early Child Development and Care*, *22*, 137-146.

Phaneuf, L., & McIntyre, L. L. (2007) Effects of individualized video feedback combined with group parent training on inappropriate maternal behavior. *Journal of Applied Behavior Analysis, 40*, 737-741.

Puddy, R.W., & Jackson, Y. (2003). The development of parenting skills in foster parenttraining. *Children and Youth Services Review*, *25*, 987-1013.

Redding, R.E., Fried, C.B., & Preston, A. (2000). Predictors of placement outcomes in treatment foster placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *Journal of Child and Family Studies*, *9*, 425-447.

Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. *Journal of Applied Behavior Analysis, 10,* 349–367.

Stoutimore, M.R., Williams, C.E., Neff, B., & Foster, F. (2008). The Florida child welfare behavior analysis services program. *Research on Social Work Practice*, *18*(5), 367-376.

Van Camp, C. M., Montgomery, J. L., Vollmer, T. R., Kosarek, J. A., Happe, S., Burgos, V., & Manzolillo, A. (2008). Behavioral Parent Training in Child Welfare: Maintenance and Booster Training. *Research on Social Practice*, *18*(5), 392-400.

Van Camp, C. M., Vollmer, T. R., Goh, H.L., Whitehouse, C.M., Reyes, J., Montgomery, J. L., Borrero, J.C. (2008). Behavioral parenting training in child welfare: Evaluation of skills acquisition. *Research on Social Practice*, *18*(5), 377-391.

APPENDICES

Tool: Stay Close

Keep the time of this role play to around 1 minute.

Trainer tells the Participant:

- ✓ You are in the kitchen getting a drink out of the refrigerator.
- ✓ Your 12-year-old child comes home from school and sits at the kitchen table.
- ✓ (S)he looks sad.
- ✓ Show me what you would do.

Co-Trainer's Role:

- You are 12 years old.
- You come home from school and walk through the door looking sad. Your best friend at school is moving to [pick a city that is over 100 miles away] at the end of the [semester or month]. You are very upset at the thought of losing your best friend. You want to talk to your caregiver about it.
- Sit at the kitchen table away from your caregiver. (When you sit at the table, be far enough away that the caregiver must move in order to be within arm's length and or to touch you.)
- When you begin to discuss your friend moving, respond morosely and make emotional comments such as: I had a shitty day, this sucks, it's stupid and I hate this.
- Make these types of comments intermittently.
- Stop immediately if/when an empathy statement is made.
- If the caregiver asks questions, answer them, without talking too much.
- Avoid eye contact until the caregiver makes an empathy statement.
- Since problem solving is not part of Stay Close, especially prior to making an empathy statement, respond with more verbal junk (ask a "why" question or argue with the caregiver).
- If the caregiver doesn't ask why you are so sad, complain about your friend moving so that the role play continues.
- Remember that you want to talk to your caregiver.

Trainer:

- 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.
- **Getting close** and **relaxed body language** must occur by the halfway point for it to be scored as "yes."
- If an **appropriate touch** occurs, even at the very end, it is scored as a "yes."

Trainer: ⬛STOP the role play when you have the information needed

Tool: Reinforcement

Trainer tells the Participant:

- ✓ Your 16 year old child always folds and puts his/her laundry away.
- ✓ Today, you noticed he/she went above and beyond and folded and put away the laundry for the entire family.
- ✓ You just came home from work
- ✓ He/she is currently up in their bedroom
- ✓ Show me what you would do.

Co-Trainer's Role:

- You are in your room reading a magazine.
- When caregiver comes in, say "hi mom/dad"
- Continue to read your magazine without making eye contact.

Trainer: ⬛STOP the role play when you have the information needed.

Tool: Set Expectations

Trainer tells the Participant:

- ✓ You want to set up a new plan to get your child to feed the dog in the morning before school.
- ✓ They have helped you in the past, and now it is time for them to do it on their own.
- ✓ You want the child to feed the dog each morning before school.
- ✓ Your child loves to ride her/his bike to school.
- ✓ You want to work out a plan so that every day the dog is fed before school, the child earns the privilege of riding her/his bike to school.
- ✓ If the dog is not fed, then (s)he does not earn the privilege of riding the bike and will have to take the bus to school.
- ✓ Ask the participant: "When would you talk to the child about the plan? Who would be there?"
- ✓ Show us how you would tell your child about this plan.

Co-Trainer's Role:

- You are the 10-year-old child.
- You hate riding the bus.
- Listen to you caregiver's plan.
- Say, "I don't like feeding the dog. His food smells."
- Show that you are pleased with the opportunity to ride your bike.
- Display junk behavior when discussing riding the bus as a consequence of not feeding the dog (for example, "And if I don't feed the dog, I've got to take the stupid bus.").
- State the expectations back to the caregiver while displaying mild junk behavior (for example, tone of voice, body language, choice of words).
- Ask, "Why do I have to feed the dog?"
- Appropriately restate the expectations to the caregiver.

Trainer: **STOP** the role play when you have the information needed.

Tool: Pivot (one child)

Trainer tells the Participant:

- ✓ You are in the kitchen with your 11-year-old.
- ✓ You have just finished eating dinner.
- ✓ Tell him/her to take out the garbage.

Co-Trainer's Role:

- You are the 11-year-old child.
- You are in the kitchen after dinner.
- You do not want to take the garbage out.
- You have just been told to take out the garbage.
- Whine, "But I hate taking out the shitty garbage."
- You roll your eyes, slam your hand on the table, and then slowly get up.
- Walk very slowly, shuffling your feet, pick up the garbage.
- Say: "How come I always have to take the <u>damn</u> garbage out?"
- Emit some more junk, but pause occasionally, allowing the caregiver time to speak.
- Once the garbage is out, slam the door, pick up your magazine, and say, "There, are you happy now?"

Trainer: 🛑 the role play when you have the information needed.

Tool: Redirect

Trainer tells the Participant:

- ✓ You have a 2 yr old child and she is looking for something to drink.
- ✓ You see he/she is reaching for a piping hot cup of coffee instead of her/his sippie cup.
- ✓ Show me what you would do.

Co-Trainer's Role:

- You are the 2-year-old child reach for the piping hot cup of coffee.
- If you are redirected, give a brief bit of whining and crying and briefly resist taking the sippie cup, but not for more than three to five seconds.
- If there is no intervention, spill the coffee on you and start screaming.

Trainer: STOP the role play when you have the information needed.

Reinforcement Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Use specific verbal praise				
2. Provide a potentially reinforcing consequence, if needed.				(Circle those provided): • Social Interaction • Appropriate touch • Tangible item • Privilege • Break from task
3. Immediately provide a positive consequence.				
4. Sincere body language (facial expression, tone of voice and body language.) [1]				
5. Stay Focused (avoid junk behavior)				

	Yes	No	N/A	Comments
6. Stay Cool and use no caregiver traps				

Trainer's Notes:

1. Score "No" if there is any instance of inappropriate expression, tone of voice, or body language. If the observation is a competency check-off, caregiver should tell you how they would make sure the consequence is reinforcing without prompting.
2. Step 6 is scored on its own and does not effect other steps in this tool.
3. If arms are crossed, count step 4 as No.
4. If the CG scores yes on 1 or 2, then if done immediately, score yes for 3.

Overall Comments: (Circle any caregiver traps used: sarcasm/teasing; criticism; threats; arguing; questioning; lecturing; despair (bribing, pleading, hopelessness; force; sudden subtraction; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Redirect Tool Checklist

Participant Name: _____

Behavior Analyst: _____Date: _____

Step	Yes	No	N/A	Comments
1. Get close 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)"				

Step				
4. Give an opportunity for the child to engage in the appropriate behavior on their own. 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. Acknowledge when the child does the appropriate behavior				
6. Stay Focused (avoid junk behavior)				
7. Stay cool and use no caregiver traps				

Overall Comments: (Circle any caregiver traps used: sarcasm/teasing; criticism; threats; arguing; questioning; lecturing; despair (bribing, pleading, hopelessness; force; sudden subtraction; one up-man-ship; silent treatment; telling on them to others. Be specific.)

1. Score a yes for step 3 if the caregiver makes this statement at any time during the role-play
2. Score a yes for step 5 if the caregiver provides any verbal statement or comment about the appropriate behavior (i.e., yes, that's right, wee wee, thank you)

Set Expectations Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Set the stage (Time away from the behavior and uninterrupted) [1]				
2. Praise Previous				
3. State the expectation clearly and specifically.				

4. If the child asks "Why?"				
5. State the consequences for meeting the expectation.				
6. State the consequences for not meeting the expectation				
7. Ask the child to restate the expected behavior				
8. Ask the child to restate the consequences for meeting				
9. Ask the child to restate the consequences for not meeting				
10. Acknowledge the child's restatement.				
11. Stay Focused (avoid junk behavior)				
12. Stay cool and use no caregiver traps				

Trainer's Notes:

1. Ask participant to describe when, where, and how setting expectations is occurring (i.e., time, place).
2. Score yes if the reason for doing the behavior is a benefit to the child.
3. If the caregiver did not ask for a restatement, wait until the end of the conversation and then provide the restatement to score step 7.
4. Score a yes for step 7 if the caregiver provides any verbal statement or comment about the appropriate behavior (i.e., yes, that's right, you got it, thank you)
5. Score a yes only for step 3 if the caregiver states specifically when (i.e. before school). Stating the time of day only is not specific enough and would score as a No.

Overall Comments: (Were any caregiver traps used: sarcasm/teasing; criticism; threats; arguing; questioning; lecturing; despair(bribing, pleading, hopelessness; force; sudden subtraction; one up-man-ship; silent treatment; telling on them to others? Be specific.)

Stay Close Tool Checklist

Participant Name: _____

Behavior Analyst: _____ Date: _____

Step	Yes	No	N/A	Comments
1. Get physically close to the child (move toward child and be within arms reach, etc.)				
2. Touch appropriately (pat, hug, rub, etc.)				
3. Appropriate body language (facial expression, tone of voice and body language.) [1]				
4. Ask open-ended questions (what? who? how? when? where?) [2]				
5. 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.) [3]				
6. Use empathy statements. (Act like a mirror and reflect the child's feelings, express understanding, caring, etc.)[4]				
7. Stay Focused (avoid junk behavior)[5]				
8. Stay cool and use no caregiver traps				

Trainer's Notes: After step 3, steps do not have to be completed in any particular order.

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

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

[3] If problem-solving is used without the child asking for it, score "no" for step 5. If two or more problem solving statements occur consecutively, score as lecturing. Score no for step 5, if they talk more than the child, interrupt the child, and/or change the topic. If the trainer does not provide an opportunity, count as N/A.

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

[5] A single instance of attending to undesirable behavior throughout the role play will be scored "no" for step 7. If the role-play is ended early by the caregiver, score steps 7 & 8 as N/A.

Overall Comments: (Circle any caregiver traps used: sarcasm/teasing; criticism; threats; arguing; questioning; lecturing; despair (bribing, pleading, hopelessness); force; sudden subtraction; 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
✓ Say nothing about the junk behavior. (For example: Don't say, "Stop that now!" or "Quit doing that!")[1]				
✓ 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]				
✓ Turn to another child, person, or activity. (For example: Read a book or praise another child for behaving appropriately.)				
✓ Immediately once the child who displayed junk behavior behaves appropriately; acknowledge the appropriate behavior of this child.				

✓ Stay cool and use no caregiver traps				

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 caregiver traps used: sarcasm/teasing; criticism; threats; arguing; questioning; lecturing; despair (bribing, pleading, hopelessness); force; sudden subtraction; one up-man-ship; silent treatment; telling on them to others. Be specific.)

Appendix C: Role-play scenarios for Pre/Postbooster Training Assessments

Stay Close

General instructions for trainer acting as child:

- Begin role play sitting or standing far enough away so the caregiver has to move towards you
- 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
- Stop these comments immediately once an empathy statement is made
- Avoid eye contact until the caregiver makes empathy statement
- If caregiver asks questions, answer them without talking too much
- Respond to any problem solving with more junk behavior
- If the caregiver doesn't ask why you are upset, complain about your issue so that the role play continues.
- Remember that you want talk to your caregiver.

Scoring tips

- 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.
- Getting close and relaxed body language must occur by the halfway point for it to be scored as "yes."
- If an appropriate touch occurs, even at the very end, it is scored as a "yes."
- End the role play when you have the information needed.

Role Play Scenarios

- Someone made fun of my bike
- Just found out friend has cancer
- Someone at school is bullying me
- This boy took my lunch from me on the bus this morning.
- My favorite teacher is sick and we will have a new teacher for the rest of the year.
- My teacher asked me to read in front of the class today and I messed up and the class laughed at me.
- This girl at school is spreading rumors about me that are not true.
- This boy at school told me my caregivers don't love me anymore.
- My best friend and I got into a fight and she is not talking to me anymore.
- An older student called me stupid and ugly today.
- My mother missed out visit today.
- My father was supposed to call yesterday and he didn't.

Use Reinforcement

General instructions for trainer acting as child:

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

Role Play Scenarios

- Come home and immediately do your homework
- 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
- You're 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 assignments two days before it is due.
- You're loading the dishwasher.
- You're mowing the lawn.
- You're taking out the trash.

Redirect-Use Reinforcement

General instructions for trainer acting as child:

- 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, stomping feet, saying "I can't do it", etc., but not for more than three to five seconds.
- If there is not intervention, continue to engage in the behavior.
- If the caregiver redirects you to an alternative 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 Play Scenarios

- You see your 3 YO throw small plastic toy in bassinet with your 2 month old
- 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 war 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

Set Expectations

General instructions for trainer acting as child

- Tell the caregiver "your child rarely does X, the last time they did X was last (pick a day within the past week). You want them to do X ever day.
- You child likes Y (and dislikes Z if appropriate)
- You want to work out a plan so when they do X, they get Y
- Start off by asking "When would you want to talk to the child about this plan and who would be there"?
- Make sure to ask for a benefit (unless the caregiver describes the benefit before you have a chance to ask)
- Make sure to ask for a negotiation (e.g., what if it rain?)
- Give the caregiver a chance to ask you to restate that behavior/consequence; if the role play is about to end and they have not, restate the behavior/consequence on your own so they have a chance to praise
- Engage in junk behavior during the role play

Role Play Scenarios

- Empty the dishwasher after school, earn riding skateboard
- Doing homework – earning to go to the basketball game
- Going to the store and not asking for candy – earn candy
- Keep clothes off floor in room – earn favorite CD
- Wash face every morning – earn bringing lunch
- Practice spelling words every week night – earn watch cartoons for 30 min
- Put dishes in dishwasher after dinner every night – earn access to favorite video game
- Put dirty clothes in hamper – earn renting video on Friday night

- Eat dinner – earn dessert

Pivot

General instructions for trainer acting as child

- If doing individual child scenario, start with 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, once 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 Play Scenarios

- 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 (one plays with water)
- Asking 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)