The Effects of Role-Playing on the Development of Adaptive Skills in a Parent Training Program

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The Effects of Role-Playing on the Development of Adaptive Skills in a 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 Studies
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Dedication

To my mother, Sylvia, who selflessly gave me babysitting, chef and chauffeur services. To my father, Argelio, who lent me his private chef and chauffeur. Thank you for such love and support. My daughter will be a better person because of the sacrifices the two of you have made. To my sister, Doreena Lynn Maikel Izquierdo, whom without such an inspiring role model I would have never considered much less strived for something as challenging as a Master’s Degree. Thank you for such support and encouragement, for the hours of help you freely gave in researching, developing and perfecting the ideas for this project. To my best friend Odalys, thank you for being my sounding board, my editor, and my personal cheerleader. Thank you to my sister Gigi, sister-in-law Nancy, and mother-in-law Adelfa, my backup babysitters. To my husband, Nelson Del Valle, you wonderful man you! You pushed me to discover my passion, and then never allowed me to waver from my goal. Thank you for all your love and support financially, emotionally and physically. You’ve been my courier, my tech support, and my personal drill sergeant. To my daughter Delsé Carina Rodriguez-Del Valle who motivates me to try and make this world a better place. This degree is for you in many ways – to give you a healthier and brighter future, and to give you yet another strong Hispanic female role model to look up to. Greenbean, in my struggles to achieve this goal know that not one day passed that I did not put you first. I was always first and foremost your mother, and you were and always will be my first priority. Family comes first, and this list of dedications is a testament of that value I want to pass on to you.
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I would like to also acknowledge the parents who volunteered for my study. You were God sent. Know that your 6 weeks of long nights has made a mark in history and will not only affect the “Winning at Parenting” workshop, but may just help other parent trainings too. Thank you for your time and effort. Thank you for wanting to and taking the time to learn how to be better parents, and not being afraid to ask for help. May God bless you. My hope is that one day we will hand out parenting manuals when parents leave the hospital with their newborns!
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Chantell A. Rodriguez-Del Valle

ABSTRACT

Parent training programs are widely used to remediate ineffective strategies being used by parents of children with maladaptive behaviors. While there are a multitude of parenting workshops available, it has been estimated that over half have no established effectiveness. The purpose of this study was to advance our knowledge regarding the effects of modeling and role-playing (in an experimentally controlled design), used to supplement the parent workshop called “Winning at Parenting” and enhance development of adaptive parenting skills of participants.

This study trained parents in the behavioral techniques of clear communication, differential attention, and time-out procedures via modeling by the instructor, role-playing with the parents, and instructor feedback to parents. A multiple-baseline design across four participants was used in an experimentally controlled manner to demonstrate the positive effect of modeling and role-playing on the development of these adaptive skills in a parent training program.

Two research questions were analyzed. The first considered whether participants would increase their use of adaptive parenting strategies via modeling, role-playing and instructor feedback, within the multiple baseline design. The results clearly showed a mean increase in correct demonstration of each target behavior for each parent only after
the treatment condition was introduced, indicating a significant treatment effect. Furthermore, because there was no overlap of data points from baseline to treatment, changes in level were evident, providing a strong case that behavior was changed due to treatment effects. Although trend of the behaviors in baseline varied, data points in the treatment phase for each target behavior for each parent made such a dramatic and immediate jump that they each were indicative of a treatment effect. These findings are consistent with previous research demonstrating that the use of modeling and role-playing are superior to readings and lecture-style for parent training programs.

The second question considered whether or not parent’s ratings of competence, depression, and life stress, as measured on the Parenting Stress Index (PSI), would change as a result of the intervention. Results showed no clear trends in data for the effects of treatment on the PSI scores.
The most frequent reason for initiation of outpatient and inpatient youth referrals (from home, schools, and physicians) to mental health clinics is disruptive behavioral disorders; and consequently, “estimated to be the most costly mental health problem in the United States” (Bernal, Klinnert & Schultz, 1980; Kazdin, 1995; Keenan & Wakschlag, 2000; Luby & Morgan, 1997; Nock & Kazdin, 2002). Since 1996, there has been a steady rise in the number of children (17 and younger), being involuntarily confined under the Florida Mental Health Act. Youth are the most significant population identified for prevention given the variety of research that states disruptive behavior such as aggression, oppositional defiant and antisocial behavior, and other conduct problems between the ages of 8 and 17 are stable predictors of criminal behavior, substance abuse/dependence, and mental disorders in adulthood. Depending on the evaluation from the mental health facilities, a child can be recommended for medication, psychotherapy, or a combination of the two. It is the responsibility of the parent(s) to follow-up with recommendations. Florida is a parental liability state, and parents can be court ordered to participate in the child’s psychotherapy and/or parent training classes for themselves. There are a variety of parent trainings offered, but there are limitations associated with most of the trainings. For instance, some parenting programs are not research-based, some do not involve the child, and some do not teach skills parents can use for their specific needs but rather seek an attitude change about parenting. Furthermore, in such
court ordered cases oftentimes the child has been removed from the parent’s custody. These circumstances limit ways the parent can retain and/or practice their new training skills until custody is returned to them. Lastly, some programs have no follow-up procedures to gain feedback on what works and what requires change. A report for The Center for Mental Health Services lists three components of a successful parenting program: it builds cognitive and behavioral skills, promotes awareness and regulation of emotions, and improves parent-child relationships (Greenberg, Domitrovich & Bumbarger, 1999). “Winning at Parenting” is a parenting workshop that incorporates all three components of a successful program. The present study will endeavor to enhance this existing parenting workshop through repetitive modeling and role-playing of behavioral parenting techniques such as clear communication, differential attention and time-out procedures. This style of active learning coupled with practice effect and feedback from the instructor is hypothesized to increase the use of such adaptive parenting strategies, as well as increase the parent’s comfort level and likelihood of implementing these techniques outside of a clinical setting.
Chapter Two

Literature Review

What Leads to Parent Training

The most frequent reason for initiation of outpatient and inpatient youth referrals (from home, schools, and physicians) to mental health clinics is disruptive behavioral disorders; and consequently, “estimated to be the most costly mental health problem in the United States” (Bernal, Klinnert & Schultz, 1980; Kazdin, 1995; Keenan & Wakschlag, 2000; Luby & Morgan, 1997; Nock & Kazdin, 2002). Since 1996, there has been a steady rise in the number of children (17 and younger), being involuntarily confined under the Florida Mental Health Act (McGaha & Stiles, 2001). “Child noncompliance is one of the most frequent reasons for the psychiatric referral of young children” (Kalb & Loeber, 2006). Adolescents are the most significant age group identified for prevention given the variety of research that states disruptive behavior such as aggression, oppositional defiant and antisocial behavior, and other conduct problems between the ages of 8 and 17 are stable predictors of criminal behavior, substance abuse/dependence, and mental disorders in adulthood (Farrington, Loeber & Van Kammen, 1990; Huesmann, Lefkowitz, Eron & Walder, 1984; Kolko, 2002; Kratzer & Hodgins, 1997; Moffitt, 1993; Stattin & Magnusson, 1989). In the Report of the Surgeon General’s Conference on Children’s Mental Health, The U.S. Department of Health and Human Services reported that, “child mental disorders persist into adulthood; 74% of 21 year olds with mental disorders had prior problems… [and] externalizing disorders that
include disruptive behaviors and more aggressive kinds of behavioral problems…” show high rates of stability (DHHS, 2000). Furthermore, it is often externalizing behaviors, not necessarily poor achievement, that lead students to be assigned to special education classrooms because their behavior is so disruptive and unmanageable in the general classroom (Oswald, Best, Coutinho & Nagle, 2003; Walker, Sprague, Close & Starlin, 2000). “African American children may be placed in segregated classrooms as a result of behavioral characteristics associated with their cultural background” (Boyd & Correa, 2005; National Research Council, 2002). A study conducted by Dr. Mark Greenberg from Pennsylvania State University reported that, “48% of children with behavior problems in kindergarten were already in special education by fourth grade” (DHHS, 2000). The results of Wakschlag and Keenan’s study (2001) showed that “clinically significant disruptive behavior disorder symptoms interfere with developmental functioning.” A true diagnosis is critical because treatment can be quite different between a mental disorder (e.g. Schizophrenia, Bipolar Disorder), a behavioral disorder (e.g. Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder), and merely disruptive or noncompliant behavior (e.g. aggressive, antisocial). Disruptive behavior can refer to a series of behaviors predictable during the developmental process, however excessive in intensity, frequency and duration (Kalb & Loeber, 2006). Treatment for disruptive and noncompliant behaviors are often improved through psychotherapy for the child and parent training, whereas mental and behavioral disorders usually incorporate medication and psychotherapy (Barkley & Benton, 1998; Brotman, Gouley, Chesir-Teran, Dennis, Klein & Shrout, 2005; Danforth, 1998; Dumas & Albin, 1986; Eyberg, 1988; Feinfield & Baker, 2004; Henggeler, Schoenwald, Borduin,
Despite the clinical diagnosis, when minors exhibit psychiatric problems, it is the parent’s responsibility to follow-up on referrals and recommendations for treatment. Dr. Pape of the Children’s Crisis Services used the analogy: “It’s like when a kid breaks their arm. You take them to an emergency room, they evaluate them and put a cast on the arm, but they are told to follow up with their doctor. Follow-up treatment is necessary” (N. Pape, personal communication, June 15, 2005).

**Parental Liability and Responsibility for the Mental Health of the Children**

Florida is a parental liability state. There are numerous parental accountability ordinance and civil parental liability statutes in every state imposing liability on parents for the disruptive behavior of their children. The laws vary from state to state, but many cover such things as truancy, vandalism, defacement or destruction of property, and personal injury or use of a weapon in connection with any of these. These laws attempt to involve parents in the lives of their children by holding them civilly and/or criminally liable for their children’s actions. Although the effectiveness of such laws has not been evaluated in a systematic way, ineffective parental discipline, and conditions within the family such as negativity, poor parental supervision (monitoring) and involvement in children’s activities are the most predictive component of a child’s behavioral functioning predominantly with ages 9 to 17 (Forehand, 1986; Frick, Christian & Wootton, 1999; Klein & Forehand, 2000; McMahon & Wells, 1998; Stormshak, Bierman, McMahon & Lengua, 2000; Williams & Forehand, 1984). Penalties to parents for a child’s violation of the law can include financial responsibility for restitution
payments and court costs; financial responsibility for detention, treatment, and supervisory costs; participation in treatment, counseling, or other diversion programs; and criminal responsibility and possible jail time for parents found negligent in their supervision. Florida has also enacted legislation that requires parents to participate in their child’s community service sentencing, and attend any court-ordered counseling or other treatments after their child is in trouble with the law (Szymanski, 1999). In addition, Florida allows the “juvenile court to order parents to attend a court-approved parental responsibility training program/parent education program” and enforces statutes requiring parents to enroll in family treatment, counseling and/or probation with their children (Szymanski, 1999). Such parental liability is labeled “vicarious liability” and begins when the state considers the child capable of deciding whether or not to engage in behavior – typically around age eight – in which parents are liable from this point on to adulthood (Szymanski, 1999). The rationale is that the parent is capable of exercising reasonable control over their child and providing age-appropriate supervision.

**Research Supporting Parent-Child Interactions**

Parenting practices and parent-child relationships are perhaps the most critical factors in identifying, assessing, and implementing a child’s mental health and behavioral treatment. A profuse amount of studies both experimental and observational have concluded that negative parenting practices consistently predict maladaptive behaviors in children of all ages. For instance, punitive interactions and lack of positive reinforcement, excessive corporal punishment, coercive and inconsistent parenting have repeatedly been linked to and predictive of disruptive behavior problems; particularly the emergence of, and elevated rates of hyperactivity, oppositional defiant and aggressive
behaviors (Bierman & Smoot, 1991; Dodge & Pettit, 2003; Frick, Lahey, Loeber, Stouthamer-Loeber, Christ & Hanson, 1992; Frick et al., 1999; Hart, Ladd & Burleson, 1990; Patterson & Stouthamer-Loeber, 1984; Stormshak et al., 2000). According to Stormshak et al. (2000), “… punitive discipline emerged consistently as a primary correlate… [and] is clearly a core parenting deficit and may be the most relevant parenting problem to work on with children and families in clinical settings.” Frick et al. (1999) states, “Corporal punishment showed a very clear peak in its association with conduct problems in our middle age [9-12] group. In fact, the amount of variance in conduct problems accounted for by corporal punishment in this middle age group was the highest across all parenting constructs and all age groups.” There is ample research from past to present documenting the effects of physically aggressive parenting practices and more specifically spanking, that result in clinic-referred and community children engaging in elevated levels of noncompliant, aggressive and oppositional behavior at home and school (Hart, Ladd & Burleson, 1990; Mahoney et al., 2000; Stormshak et al., 2000; Straus, Gelles & Steinmetz, 1980). In 2004, 27-33% of all children screened and/or evaluated at the Children’s Crisis Services reported being physically abused (Emergency Walk-In Report, 2004). Physically maltreated children exhibit a higher rate of internalizing (anxiety, depression, etc.) and externalizing problems (antisocial, oppositional, aggressive behavior, etc.) than nonmaltreated children; and consequently, are at higher risk for experiencing mental health and behavioral disorders in adulthood (anxiety, depression, substance abuse, aggressive behavior, etc.) (Kolko, 2002; Shipman, Schneider & Sims, 2005; Stormshak et al., 2000). Two studies have focused on parental physical aggression exclusively toward their clinic-referred child. Jouriles, Mehta,
McDonald, and Francis (1997), compiled data on parental discipline toward children (ages 7 to 9 years old) referred for conduct problems. This study listed varied acts of physical aggression by the parent toward the child from “threw something at” to “used a knife or fired a gun” (Jouriles et al., 1997). Results showed 96% of mothers and 80% of fathers used at least one listed act of physical aggression within that past year (Jouriles et al., 1997). The second study by Mahoney, Donnelly, Lewis and Maynard (2000), was the first to examine physical aggression by parents toward their clinic-referred youth using a wider range of age (2 to 17 years old). Results from this study concluded that “Mothers and fathers of clinic-referred youth generally reported higher prevalence rates of corporal punishment and severe physical aggression than parents from the general population…[and] clinic-referred mothers and fathers were twice as likely to use corporal punishment with adolescents (ages 13 to 17) than parents from the community” (Mahoney et al., 2000). Some research links social-skills deficits in children to the predictable and repetitive cycles of aversive interaction among familial members, resulting in a child’s antisocial behavior (Berger, 1991; Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998; Patterson & Reid, 1984; Pollack, 2004; Rhule, McMahon & Spieker, 2004). Decreases in children’s oppositional behavior have been shown to positively correlate with decreases in mother’s inappropriate attention (Koegel, Egel & Williams, 1980; Wahler, Cartor, Fleischmann & Lambert, 1993). Parent-child interactions that lack warmth and involvement have predicted disruptive behaviors such as aggressive, noncompliant and oppositional behaviors (Frick et al., 1999; Greenberg & Speltz, 1988; Pettit & Bates, 1989; Pettit, Bates & Dodge, 1997; Stormshak et al., 2000). “Warmth/Involvement emerged as a significant (inverse) predictor of oppositional
behavior, adding unique variance beyond the contributions of both punitive and aggressive parenting” (Stormshak et al., 2000). In a meta-analysis conducted by Loeber and Stouthamer-Loeber (1986), results from over 300 studies concluded that lack of parental monitoring and lack of involvement in activities with the child were the strongest and most consistent links with a child’s antisocial behavior. Resnick, Bearman, Blum, Bauman, Harris, Jones, et al. (1997), conducted a national longitudinal study of adolescent mental health. Results from nearly 100,000 adolescents from grades 7 to 12, indicated that “parent-family connectedness” and “perceived school connectedness” affected behaviors most. “Parent-family connectedness dramatically influenced the level of emotional distress adolescents suffer, their level of depression and suicidality, how much they abuse drugs and alcohol, their academic success, general criminal proclivities, and even to some extent how involved in violence they may become” (Resnick et al., 1997). Other studies have shown that maternal aversiveness predicts child deviant behavior; and vice versa, a child’s aversive behavior predicts maternal aversiveness (Panaccione & Wahler, 1986; Sanders, Dadds & Bor, 1989). In a study specifically focused on aggressive and noncompliant behavior, Feinfield and Baker (2004), showed that “improved parenting practices mediated reductions in child behavior problems and that child improvements mediated changes in parent attitudes and stress.” More specifically, families with hyperactive, oppositional and conduct-disordered children are reported to engage in higher rates/levels of aversive interactions with a reciprocated coerciveness (Dadds, Sanders, Morrison & Rebgetz, 1992; Danforth, Barkley & Stokes, 1991; Mahoney et al., 2000; Querido, Eyberg & Boggs, 2001; Sanders et al., 1989; Williams & Forehand, 1984). Bell’s Control System Model (1968) introduced this
concept of bidirectional effects. It cannot be said that parenting practices alone shape behavioral problems when there are empirical studies demonstrating mutually influential behaviors between parent and child -- the child does not play a passive role but rather an active role influencing the behavior of others (Bijou & Baer, 1978; Carr, Taylor & Robinson, 1991; Nock & Kazdin, 2002; Wahler & Dumas, 1986). Fagot (1984), demonstrated that a child’s aggression does systematically influence adult behavior. A child’s language and communication skills influences parental responding; and overall family functioning is affected when a child has serious behavior deficits (Carr et al., 1991; Nock et al., 2002). More recently, studies are reporting evidence that younger siblings of behavior disordered children, and/or with a family history of antisocial behavior, are at risk for developing conduct problems due to such a familial environment (Bank, Burraston, & Snyder, 2004; Compton, Snyder, Schrepferman, Bank & Shortt, 2003; Reid, Patterson & Snyder, 2002). Nevertheless, Rhule, McMahon, and Spieker (2004) concluded that parent training may “…prevent the intergenerational transmission of antisocial behavior.” The literature reviewed presents data showing that parents can learn to and successfully change their interaction style with their children, and as a result change the behavior of their children (Brotman et al., 2005; Danforth, 1998; Eyberg, 1988; Eyberg & Robinson, 1982; Feinfield & Baker, 2004).

Parents Need Specific Skills to Raise a Child

It is common for excited parents-to-be to attend prenatal classes to educate themselves on the birthing process and techniques used to bring a baby into the world (natural birthing, C-Section, underwater birthing, etc.). Some parents even seek postnatal classes to learn techniques to care for their newly arrived baby (breastfeeding, car seat
safety, infant/child CPR, etc.). But it is not so common to hear of parents attending classes on child development, toddler tantrums, or teen rebellion. While most parents are prepared to nurture the physical needs of a child, many are not prepared for the emotional and socialization needs of a child. Studies have shown that there are fewer behavior management resources and increased stress factors among parents of disruptive children (Feinfield & Baker, 2004; Forehand & Long, 1988; Webster-Stratton & Hammond, 1997). The onset and maintenance of disruptive behavior has been connected to high levels of chronic stress among the parent(s) (Feinfield et al., 2004). In contrast, parents who have completed parent training have shown increases in their sense of competence, and significant decreases in child-related stress measures (Feinfield et al., 2004). Parents tend to rely on attitudes, models and experiences (their own parents, relatives, friends, etc.) about parenting when they really need skills and techniques to raise a child.

Parenting skills have been a topic of research worldwide since the early 1800s (Croake & Glover, 1977; Hess, 1980). The focus of parenting has changed repeatedly from philosophies of parenting versus moral virtues, between parental control and parenting styles, parent-child relations versus children’s personalities, and cognitive interventions versus child-rearing methods. Lastly, a shift toward training parents in specific techniques to help them become the change agents would restructure traditional therapist-client models. This prevailing shift began in the late 60’s when the field of behavior modification introduced behavioral training of parents (Berkowitz & Graziano, 1972; Dumas, 2005; Graziano & Diament, 1992).
Parent Training

Parent training is widely used to remediate ineffective strategies being used by parents of children with maladaptive behaviors. Furthermore, “parent training programs make up the largest and most well-researched interventions for noncompliant children” (Kalb & Loeber, 2006; McMahon & Wells, 1998). While there are multitudes of parent training programs available, it has been estimated that over half of these programs have no established effectiveness (Henggeler et al., 1998; Sondheimer, Schoenwald, & Rowland, 1994). Despite documented positive results of some parent training programs, there remains a lack of resources and services of evidence-based treatments, such as behavioral training, used in clinical practice. A member of the Surgeon General’s task force, Dr. John Weisz from the University of California, reported multiple reasons for the lack of evidence-based treatments:

“First, there is no official stamp of approval for these [parent training] treatments, nothing like the kind of certification tested medications receive from the FDA… Second, public awareness of evidence-based treatments is limited. There is no agency or industry to publicize the scientific evidence for psychotherapy, nothing parallel to the pharmaceutical industry… Third, dissemination is slowed by the fact that gaining expertise in most psychotherapies requires considerable hands-on training and supervision… Fourth, because most of the evidence-based treatments have been developed and tested primarily outside community practice settings, they may need to be adapted to facilitate adoption and everyday use in practice settings…” (DHHS, 2000).
Three Key Components of a Successful Training

Referencing a report for The Center for Mental Health Services, panelist Dr. Mark Greenberg from Pennsylvania State University listed three key components of successful parenting programs: “They (1) build cognitive and behavioral skills that are protective, (2) help families and children gain better emotional awareness and regulation, and (3) improve the relationships of children with their parents and peers” (Greenberg, Domitrovich & Bumbarger, 1999). When planning and implementing a parent training program, the parent-child interaction pattern plays a significant role.

Top Three Styles of Training

Most parent training programs are derived from the three primary models of therapy: Adlerian, reflective (or cognitive), and behavioral (Medway, 1989). A common thread found woven throughout these top three models is an attempt to improve parent-child communication, and to change parent-child interaction via consequences. There are of course eclectic models as well, but for purposes of this paper Adlerian, reflective, and behavioral based trainings were reviewed because they are empirical versus descriptive models, have been tested with community and clinic-referred populations, and have established permanence in the field.

Adlerian Training. Adlerian training was developed in Vienna by Alfred Adler in 1922 (Croake, 1983). Adler reasoned that if everyone gained knowledge of “effective methods for cooperating and living democratically… and if these methods were mastered, emotional maladjustment would not be present” (Croake, 1983). He practiced in traditional clinics, with no emphasis on parent training. Rudolf Dreikurs, a former student and colleague of Adler, interpreted Adler’s ideas here in America with the intent
of training nonprofessionals in the application of Adler’s methods – including parents in regard to child rearing. “The theoretical assumption is that the [children’s] misbehavior is purposive and directed toward the parents” to gain attention, obtain power or seek revenge (toward an authoritarian parent), or display extreme feelings of inadequacy and not belonging (Croake, 1983). Once the connection between the misbehavior and the parent is diagnosed, the parents gain emotional awareness. They then learn to respond in ways that promote feelings of significance and status within the family, and encourage the child to use constructive means of communication; consequently, the child responds more cooperatively improving the relationship. All Adlerian parent trainings “rely heavily on diagnosing the goal of misbehavior in specific situations…,” and teaching cooperative remediation techniques (Croake, 1983). Adlerian training does not condone punishment; rather specific techniques involve natural and logical consequences to maintain appropriate behavior. The methods and techniques are ideally developed for preadolescent children; however, throughout the years adaptations for adolescents have been developed. Dinkmeyer and McKay’s (1976), *Systematic Training for Effective Parenting* (STEP) is the most prevalent parent training program based on Adlerian principles; and Dinkmeyer (1983) offers a manual for teens as well – *STEP/Teen* (Croake, 1983).

**Reflective Training.** Carl Rogers’ (1951) person-centered therapy and his emphasis on communication techniques are the foundation for reflective parent training (Medway, 1989). This style of training teaches the parent to be more cognizant of their child’s feelings, and helps the parent to accept and be more responsive to their child’s feelings; thus, altering parent-child communication and the child’s behavior as well
(Tavormina, 1975; Medway, 1989). Rogerian based techniques include “active listening”, using “You feel…” statements to reflect the child’s feelings; the use of “I-messages” for parents to communicate their feelings; and negotiating solutions agreeable to both parent and child (Gordon, 1975). Gordon’s Parent Effectiveness Training (P.E.T.) is the most commonly used reflective program (Medway, 1989).

Behavioral Training. Behavioral training of parents is the most widely used and generally the treatment of choice for families of children with disruptive behaviors (Dumas, 2005; Graziano & Diament, 1992; Medway, 1989). Comparable to Adler’s philosophy, behavioral science believes that all behavior is purposive - “the universe is a lawful and orderly place and that all phenomena occur as the result of other events” - this belief is called determinism (Cooper, Heron & Heward, 1987). There are generally four tenets to the fundamental philosophy of behavioral parent training: 1) A functional relation exists between a person’s behavior and the contingencies they experience when interacting within their environment; 2) Maladaptive behavior is learned and maintained by these contingencies (e.g., attention, escape, avoidance); 3) Intervention techniques rely on empiricism (objective observation), and operant principles to establish contingencies that reinforce appropriate behavior and weaken disruptive behavior; 4) Maintenance and generalization of appropriate behavior rely on the process by which positive reinforcers are exchanged (Dumas, 2005; Medway, 1989). Behavioral parent training implements only empirically validated techniques, applied in a systematic and technological manner to decrease maladaptive behavior and increase socially significant behavior (Cooper et al., 1987). “Any behavior whose probability of occurrence is determined by its history of consequences,” is called operant behavior (Cooper et al., 1987). Most behavioral
trainings use an operant model and stress the critical factor of consistency both with communication and consequences (contingencies of reinforcement and punishment) (Dumas, 2005). Inconsistency is a parenting practice linked to oppositional, noncompliant and aggressive behavior in children (Stormshak et al., 2000; Wahler & Dumas, 1986). Consequences are critical because they affect future behavior.

Behavioral parent training improves parent-child communications by teaching parents to use eye contact coupled with direct and detailed requests. The structure of the request has been said to be “pivotal in determining compliance because the child must first process the verbal information before deciding whether or not to comply”; and presentation of the request also heavily influences interpretation of the parent’s request (Kalb & Loeber, 2006). “Observational studies have revealed that parents often give commands that are not specific or clear enough to be accurately understood by the child and that parents often do not allow children ample time to comply with requests” (Kalb et al., 2006). Behavioral based parent training also teaches parents actual techniques designed to change their interactions with the child; thus, altering future behavior. Empirically supported treatment has shown that, “behavior parent training affects child behavior through the changes it brings about in parenting behaviors…” (Feinfield & Baker, 2004). Two core techniques used in behavioral training are differential reinforcement and time-out. Differential reinforcement of attention consists of providing attention to all positive child behaviors, and ignoring all negative child behaviors. Time-out is defined as, “The withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified period of time, contingent upon the occurrence of a behavior” (Cooper, Heron & Heward, 1987). Antecedent stimuli,
what happens prior to a response (e.g., eye contact, direct and detailed requests), prepare
the child for what’s expected and acquire control over a response due to the association
with certain consequences (e.g., differential attention, time-out) in the past (Cooper et al.,
1987).

A unique, and particularly fruitful, parent behavioral training was Dr. Constance
Hanf’s two-stage operant model (Eyberg, 1988). Where traditionally therapists treated
the child to change behavior, Hanf targeted the parent(s) interaction patterns with the
child. The first stage consisted of the child leading a play session with the mother. The
mother was taught the technique of differential attention to intervene during
noncompliant behavior. In the second stage, the mother was to lead the play session with
the child. The mother was taught to communicate clearly, praise the child for compliance
with requests, and utilize time-out for noncompliance. Hanf’s unique approach united the
parent and child together during a therapy session, as she “coached the mother on the spot
to gain these particular skills” (Eyberg, 1988). The term fruitful is used because Hanf’s
model planted the seeds from which a variety of parent trainings have bloomed. One
sprout that has been widely used and recognized for over 25 years is Sheila Eyberg’s
Parent-Child Interaction Therapy (1988). Eyberg’s model has been successful with a
wide range of behavior problems including oppositional and hyperactivity disorders. Dr.
Russell Barkley’s program, Your Defiant Child: Eight Steps to Better Behavior, is
another of Hanf’s sprouts claiming to be “one of the most commonly used and effective
parent training programs in North America for the management of oppositional and
defiant behavior in children” (Barkley & Benton, 1998).
Proposed Study Relative to Literature Reviewed

All the reviewed literature illustrates a cause and effect pattern - certain parent behaviors are conditioned by child behaviors; as well as, certain child behaviors are conditioned by parent behaviors. Popkin suggests that all the pertinent content needed for parent training has been documented in the literature and accounted for within the top three styles; the shift from content (what skills to train) to process (how the training is implemented), is what is vitally important (1989).

The present study investigated the effects of modeling and role-playing on the development of adaptive skills in a parent training program. This study was conducted within the confines of the parent education workshop “Winning at Parenting” currently offered by Children’s Crisis Services, a program of Mental Health Care, Inc. The two hour long workshop is held once a week for six consecutive weeks. It incorporates the three key components of a successful program as previously listed by Greenberg. “Winning at Parenting” is best described as a cognitive-behavioral based parent training. It helps parents gain emotional awareness and regulation by incorporating the reflective techniques of active listening and “I-messages,” combined with behavioral techniques of positive and negative reinforcement, differential attention and time-out procedures to improve parent-child interactions. The instructor utilizes a combination of lecture/discussion, modeling and role-playing to demonstrate these skills, as well as handouts to read and worksheets to complete. Modeling is most effective when repeated and demonstrated by more than one model. The workshop is supplemented by a video by Barbara Coloroso titled, “Winning at parenting… without beating your kids” (1989). This video also combines lecture with modeling and role-playing to communicate the
importance of active listening and clear commands, positive and negative reinforcement, as well as the use of consistent consequences when confronted with what Coloroso calls “the 3 cons” (1989). In the video, Coloroso models appropriate and inappropriate parental behavior to use with “Con 1” - begging and bribing; “Con 2” – anger and aggression; and “Con 3” – sulking and weeping (1989). Research has shown observed parent behavior to be differentially affected when utilizing modeling and role-playing versus discussion and readings (Danforth, 1998; Dumas & Wahler, 1983; Knapp & Deluty, 1989; O’Dell, 1974; Wahler, 1980). In a literature review by Graziano and Diament (1992), modeling and role-playing used in parent trainings produced superior outcomes to that of verbal instruction alone. Through modeling, parents observe the appropriate and expected parental behaviors and, according to the social learning theory, vicarious learning occurs (Bandura, 1977). Bandura’s explanation of vicarious learning says an individual must observe behavior being modeled, imitate the model (role-play), and have motivation for imitating the model (1977). Role-playing is a form of active learning – learning by doing. It is general knowledge that information is better received and learned through active learning than lectures and readings. Lower socioeconomic status (SES) mothers showed more success at demonstrating behavioral techniques after exposure to modeling, role-playing and coaching, and less success with discussions and readings; whereas middle-SES mothers succeeded in either program (Forehand & McMahon, 1981; Knapp & Deluty, 1989). Active learning is not a new concept, becoming well known back in the early 1900’s when John Dewey expressed his belief that we should learn by experience, “In this way, students would not just gain knowledge but would also develop skills, habits and attitudes necessary for them to solve a wide
variety of problems” (Dewey, 1954). Edgar Dale claims that, “After two weeks we tend to remember 10% of what we read, 20% of what we hear, 30% of what we see, 50% of what we hear and see, 70% of what we say, and 90% of what we say and do” (1969). Referring back to Bandura’s explanation of vicarious learning, there are a few clearly motivational aspects for parents attending the “Winning at Parenting” workshop. For those parents who are court-ordered, motivation is twofold: they are mandated to pass the class and could be penalized for not complying; they also require certification from the class as a step toward maintaining/regaining custody of their children (Irueste-Montes & Montes, 1988). For those parents attending voluntarily, one could say they show internal motivation by seeking out training that can help their situation before it escalates to a court-ordered level. In a study conducted by Irueste-Montes et al. (1988), results showed that court-ordered parents in comparison with noncourt-ordered parents participated in treatment and improved at equal levels – increased positive interactions and decreased negative interactions with their children. Requiring observers to imitate the model(s) and providing them with feedback and positive reinforcement can enhance vicarious learning. Parent dyads in the “Winning at Parenting” workshop take turns role-playing, which allows each parent to engage in and practice the goals of the workshop. Unfortunately, due to time constraints parent dyads are able to participate in only one role-play during the workshop, and that role-play is based on the initial opening of a conversation between the parent and child – clear communication. The workshop does not rehearse a parent-child situation from start to finish. Parents are unable to practice/rehearse parenting skills such as differential reinforcement and consequences like time-out. Sufficient exemplars are critical because if the stimulus class is too
narrow, parents may not adhere to treatment outside of the clinical setting (Stokes & Baer, 1977). “Improvements in performance resulting from practice opportunities that are necessarily provided in order to obtain repeated measurements are called practice effects” (Cooper, Heron & Heward, 1987). The present study examined the hypothesis that active learning coupled with practice effects via modeling and role-playing can affect the development of adaptive skills in a parent training program. Thus, the goal was to develop a variety of real-life, common problematic parent-child scenarios beginning with the initial parent-child communication through to the end of the interaction, which allowed parents to repeatedly practice clear communication, differential attention and implementation of time-out procedures, and as a result improve acquisition of skills. The technique of differential attention was a focus because some research showed that court-ordered parents continued to attend to their child’s annoying behaviors despite treatment (Dawson, De Armas, McGrath & Kelly, 1986; Irueste-Montes et al, 1988). A disciplinary technique such as time-out was also important. Firstly, in a review by Forehand (1986), parental positive reinforcement alone showed to be insufficient in altering deviant behavior of clinic-referred youth; however, when used in conjunction with time-out, deviant behavior was altered. In a review by Kalb and Loeber (2006), they stated that studies found time-out to be effective “independent of other parental effects such as attention.” Secondly, parents who use corporal punishment need an alternative means of punishing the child – not just ignoring undesirable behavior. In the literature reviewed, corporal punishment repeatedly showed a strong and stable prediction of disruptive behavior problems, and it was suggested that a critical component of any intervention be an alternative discipline method (Frick, Christian & Wootton, 1999).
Experimental analysis was accomplished via a multiple baseline across subjects design. The treatment group included parents attending the “Winning at Parenting” workshop who volunteered to meet prior to the start of each workshop, observing a total of three models, engaging in multiple role-plays and receiving constructive feedback. Parents in the treatment group showed an increase in their use of adaptive parenting strategies (clear communication, differential attention, and time-out procedures), through the use of modeling, role-playing, and feedback. Treatment participants were also more comfortable and more likely to use the behavioral techniques due to practice effects.

While the goal of treatment was to improve the acquisition of parenting skills, the significance of the behavioral parenting skills taught was that parents could learn to use these skills to effectively decrease undesirable behaviors even to the point of extinction, and possibly increase the parent’s sense of competence and reduce parental stress. “The principle of extinction states that: (a) If, in a given situation, an individual emits a previously reinforced response and that response is not followed by a reinforcing consequence, then (b) that person is less likely to do the same thing again when he or she next encounters a similar situation” (Martin & Pear, 1999). The present study instructed parents on how to use more effective commands, how to gain compliance from their child in response to a command, and how to properly and consistently employ consequences such as time-out. Feinfield and Baker (2004) suggested that parent trainings increase parental sense of competence and reduce child-related stress reported by the parent(s); thus, specific domains of the Parenting Stress Index were used to measure parental competence and stress levels pre- and post-treatment.
In addition, Knapp and Deluty (1989), recommended that although parents are able to demonstrate new skills in the clinical setting, future research should focus on methods for assisting adherence to and implementation of these skills in their natural environment. The present study provided reference cards, called “MyTell” cards (Appendix I), to all workshop participants (whether or not they participated in this study), upon completion of the workshop. “MyTell” cards depicted skills taught during the workshop and research study such as active listening and I-messages, differential attention and alternative time-out techniques, to assist parents in adherence to and implementation of their new skills outside of the clinical setting. These reference cards were important for promoting generalization across settings and parental adherence over time (Ayllon, Kuhlman & Warzak, 1982; Danforth, 1998; Hansen & MacMillan, 1990). The cards may act as self-mediated discriminative stimuli once the parent leaves treatment, to evoke the newly learned parenting skills. “MyTell” cards focused on visual reminders of the behavioral parenting skills with limited written instructions to accommodate limited English speakers, illiterate and dyslexic parents all of which were represented in past workshops. The visual reminders of differential attention and time-out procedures were also designed as a flowchart based on research done by Danforth who suggested, “the mode of presentation may affect the effectiveness of the training program” (1998). Upon a 6-month follow-up, Danforth’s research including a Behavior Management Flowchart produced stable parenting and child behaviors among families with children diagnosed with disruptive behaviors; thus, revealing generalization across settings and over time (1998). He attributed partial success to the immediate access parents had of a visual reminder of behavioral parenting skills in a forward-chaining
manner taught during treatment. Also included on the “MyTell” cards were suggested low-cost or no-cost activities parents can play with their child that not only instills and builds upon their newly acquired skills, but also encourages parental involvement in activities with the child, family connectedness, and positive parent-child interactions -- all of which the lack of were shown to predict disruptive behavior (Loeber et al., 1986; Resnick et al., 1997; Stormshak et al., 2000). These cards were patterned after a project by The Ohio State University Cooperative Extension Service program, in which a set of 36 reference cards titled “Take a Break With Your Kids,” were developed to build strong family skills such as decision-making, communication, and problem-solving. The cards were included in McDonald’s Happy Meals for free. Upon follow-up, results from a survey of 200 women who bought a meal and received the card showed: 85% thought the cards should continue to be distributed, and approximately one-third stated they had read them and planned on keeping them (Progress Reports, 1995). Together, active learning, practice effects, and “MyTell” cards were an effort to increase adaptive parenting skills of parents attending the parent training program called “Winning at Parenting.”

Research Questions

1) Do the participants increase their use of adaptive parenting strategies (clear communication, differential attention, and timeout) through the use of modeling, role-play and feedback, within the multiple baseline design?

2) Do parent’s ratings of competence, depression, and life stress change as a result of the intervention using modeling, role-play and feedback?
Chapter Three

Method

Participants and Settings

For privacy and confidentiality purposes, the identification of all participants was withheld using instead fictitious first names for questionnaires, observations, and the discussion of results.

Parents attended the Children’s Crisis Services, “Winning at Parenting” workshop either voluntarily or under a court order. Volunteer attendance is generally via referrals from Department of Children and Families, the Children’s Crisis Services program, attorneys of custodial cases, and counselors/therapists, etc. Court ordered attendance is due to a variety of reasons such as: parent(s) accused/suspected of domestic violence and/or physical abuse against a child. The two-hour workshop is conducted once a week for six consecutive weeks, and participants are charged a $20 fee unless financial hardship is determined. Operating within the limits of the workshop registrations, the treatment proposed was implemented with parents of any age children. Participants for the study were recruited from the attendees of the parenting workshop held January 12th through February 16th of 2006. Participation was voluntary and the volunteers could have been mothers or fathers, a single parent or a couple; however, the four volunteers for the study were all mothers attending singly. A fifth mother volunteered and attended the first day of the study only, then dropped out of the study as well as the parenting workshop. Efforts were made to contact her, but she did not reply.
Treatment and data collection took place in a classroom setting inside the Children’s Crisis Services building. The classroom was separate from the room in which the workshop was conducted.

Experimental Design

To demonstrate experimental control, a multiple baseline design across participants was utilized. Using such a design, treatment was introduced to multiple participants in the same setting but at different times during the six weeks of treatment, and dependent variables were measured pre- and post-treatment. Baseline data were collected for target behaviors among all volunteer participants during weeks one and two of the parenting workshop. Beginning on week three, treatment was introduced for one parent (Sylvia), while baseline conditions continued for the remaining participants. On week four, treatment was introduced for a second parent (Ivy), while the other two volunteers remained in baseline. On week five, treatment was introduced to the final two participants (Alice and Mickey). The target behaviors of the parents experiencing treatment were expected to change in comparison to the parents in baseline not experiencing treatment. Changes in data during the staggered treatment schedule with experimental control of relevant variables, would demonstrate effects attributed to the treatment (Cooper, Heron & Heward, 1987). An important advantage to utilizing a multiple baseline design is that the withdrawal of the effective treatment is not required to demonstrate a functional relationship (Cooper et al., 1987). Although the present study was superimposed upon an ongoing parent training, significant effects for study participants were not predicted to occur until treatment was implemented. Variations in
time spent in the ongoing workshop were not predicted to have a significant impact on baseline measures.

This multiple baseline experiment included techniques to assess internal validity. First, to ensure reliable observations, observers were trained, target behaviors were operationally defined, and checks on observer reliability were implemented. Secondly, modeling by the instructor was videotaped to ensure treatment integrity, as well as procedural and instructor reliability; thus achieving internal validity. Finally, repeated measurements were used to control for internal validity and also provided more reliable descriptions of how participants’ behavior changed as a result of the treatment condition.

Graphic representations of the treatment effects were analyzed via visual analysis of data. During each phase of the experiment, data points representing the dependent variables were analyzed for mean, level and direction of slope (Parsonson & Baer, 1992). Graphic presentation of data is the most frequently used and most effective means to organize, analyze and communicate results of applied behavior analysis (Cooper, Heron & Heward, 1987). There are multiple advantages to using visual analysis of behavioral data. Here are a few pertinent to this particular study: 1) It provided the investigator with immediate and ongoing access to the history of a participant’s behavior; and with such continuous monitoring, it allowed treatment to be responsive to participants’ performance. 2) It did not require special equipment and was simple to learn by both the investigator and as feedback to the participant. 3) It “imposes no predetermined or arbitrary level for evaluating the significance of behavior change, and does not require the data to conform to certain mathematical properties or statistical assumptions in order to be analyzed” (Cooper et al., 1987). Along with advantages come disadvantages. A
couple of potential disadvantages to the visual analysis of graphs are that the ordinal scale
can be manipulated to overrate or underrate changes in behavior, and that low inter-rater
reliability can occur when determining treatment effect (Cooper et al., 1987).

**Dependent Variables**

*Clear Communication*: Clear communication included three objective
measurements: (1) eye contact, (2) direct requests, and (3) detailed requests. Clear
communication was defined as making eye contact with the person to whom you give a
direct command or request in statement form (e.g., asking the child to start, continue or
discontinue a behavior). Clear communication included details such as who, what,
where, and when. For example, “Jason, please take the kitchen garbage out to the curb
before going to bed.” In a review of child disobedience and noncompliance, Kalb and
Loeber (2006) stated that, “Both developmental psychologists and language scholars
have made important distinctions between direct commands (those commands that are
clearly stated and include a specific behavior that is expected of the child) and indirect
commands (polite commands, commands that are implied, suggestions, or commands
stated in a question form).” Some studies found indirect requests linked with more child
refusals, and direct requests with more compliance (Kalb et al., 2006). The goal of clear
communication is for the child to not only comprehend the parent’s request, but also to
know how to comply with the request and know what consequences he/she will
experience if he/she does not comply.

*Differential Attention*: Differential attention included two objective
measurements: (1) providing attention to increase desirable behavior, and
(2) withholding attention to decrease undesirable behavior. Differential attention was
defined as the use of parental attention to reinforce desirable behavior, and withholding parental attention to decrease undesirable behavior. Attention was defined as talk, praise, or affectionate behaviors from the parent that reinforce the child’s behavior. Talk was defined as conversation with the child or verbal acknowledgement of the child’s behavior. Praise was defined as positive verbal attention toward the child’s behavior (e.g., “good job”), or an expression of approval (e.g., gesturing thumbs up). Affectionate behavior was defined as the parental initiation of positive physical interactions such as a kiss, hug, pat/rub on the back, tickling, etc. Ignoring behavior was defined as withdrawing attention, physical contact or verbal interaction once undesirable behavior or inappropriate response began. Following a request, the child may attempt to divert attention away from the task by asking moot questions (“Why do I have to do it?” “Why can’t Joe do it?” etc.), and/or making irrelevant and inappropriate responses (“You’re so mean!” “None of my friends have to do that.” etc.). Parents can withhold attention by either disengaging eye contact, removing one’s self from the presence of the child, remaining silent and/or not attending to the content of the child’s diversion.

Time-Out Procedures: Time-out procedures included five components for measurement: (1) define behavior leading to time-out, (2) explain time-out rules, (3) apply time-out consistently, (4) ignoring child in time-out, and (5) reinforce desirable behavior after time-out. In a review of studies, time-out procedures correctly employed effectively reduced child noncompliance (Kalb et al., 2006). Time-out is defined as, “The withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified period of time, contingent upon the occurrence of a behavior” (Cooper, Heron & Heward, 1987). Nonexclusion time-out can be ignoring
(described above), withdrawal of a specific reinforcer (television or radio turned off, etc.), or contingent observation where the child remains a part of the setting but is removed from the ongoing reinforcer. Exclusion time-out is when the child is physically removed from the setting, and placed in a setting devoid of positive reinforcers. Once a request was made, if the child did not comply within the time specified for that activity, then a timeout procedure was implemented. Time-out was terminated at the specified time, or extended until inappropriate behavior had ceased (5 to 30 seconds – parents judgment). The following steps had to be evident for time-out to be scored as successfully implemented:

1) Define to the child the behavior(s) that will lead to time-out.

2) Explain the time-out rules (start of, expected behavior during, termination, etc.)

3) Apply time-out consistently. Follow through even if child begins appropriate behavior. Once “time-out” has been initiated, follow through is critical.

4) Parent(s) must absolutely ignore (as defined above) a child in time-out unless behavior becomes extremely destructive.

5) Reinforce appropriate behavior occurring after termination of time-out.

For the list of operationally defined target behaviors given to observers for scoring purposes, see Appendix E.

Independent Variables

Modeling: Modeling was defined as demonstration of the appropriate and expected parental behavior. Appropriate and expected parental behaviors included eye contact and the use of “I-messages”; attention following appropriate child behavior and withdrawal of parental attention following inappropriate child behavior; clear
commands/requests in statement form; and consistency with applying consequences when a child did not comply.

**Practice:** Parents practiced parenting strategies that had been modeled to them during multiple scenarios they role-played.

**Feedback:** The instructor provided feedback regarding parent(s) performance, by providing positive reinforcement for correct use of parenting strategies, as well as describing and asking for improvement of maladaptive parenting strategies.

**Observational Techniques and Measurements**

Sessions occurred once a week for approximately 10-15 minutes prior to the start of that week’s workshop. The instructor observed and measured whether or not dependent variables were demonstrated using a behavior checklist (Appendix F). Graphical presentation showed a percentage of demonstrated dependent variables. For example, there were 3 major objectives with clear communication: eye contact, direct request in statement form, and detailed information. If the participant demonstrated eye contact but neither stated a request nor gave specifics, that yielded a result of 33%.

All sessions were videotaped. Role-plays were videotaped and reviewed by the major professor, a licensed clinical psychologist, to ensure interobserver agreement and accuracy. Agreement between different observers is a necessary component to ensure target behaviors are well defined and measurement is replicable, minimize the biases of any one observer, and add credibility to the experimental effects shown or not shown (Cooper, Heron & Heward, 1987). Modeling was videotaped to ensure procedural and instructor reliability.
Two behavioral assessment methods, direct observation in the clinic and rating scales, were utilized to establish baseline measures which when compared against treatment effects determined changes in parental behaviors.

**Secondary Measures**

**Behavior Questionnaire:** A pre- and post-training parent questionnaire was used to compile information on the child’s behavior in common problematic areas such as mealtimes, bedtime, homework, and following instructions in general, to enhance the accuracy of portrayal during role-plays; as well as, measure changes in the child’s behavior at the conclusion of parent’s treatment. During the treatment phase, participating parents were asked to practice their new skills outside of the clinic with their child. On the final day of data collection, parents completed the questionnaire again to identify any shifts from baseline. Questionnaire items included real-life, common problematic areas that were based on the workshop’s historical intake data from parents of previous workshops. Items were rated on a 4-point Likert-styled scale ranging from a score of 1 for “never” to a score of 4 for “often.” Final results obtaining lower scores than baseline measures indicated improved behavior. Scores were reported by the mean percentage of each category, and by the mean percentage overall.

**Parenting Stress Index:** The Parenting Stress Index (PSI) is a self-report measure “designed as a screening and diagnostic assessment technique to identify parent and child systems which are under stress, and in which deviant development of the child is likely to take place, or where dysfunctional parenting is likely to occur” (Abidin, 1983). Portions of the PSI Parent Domain were administered pre- and post-training to assess stressful parental characteristics, competence and mood, and identify any shifts from baseline.
Items were rated on a 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” Results obtaining higher scores indicated greater stress. Parental stress scores have been shown to decrease as a result of parent training (Feinfield & Baker, 2004; Lafferty, Cote, Chafe, Kellar & Robertson, 1980; Pennington-Peters, 1998). For this study the assessment was only of the PSI dimensions related to competence (13 questions), depression (9 questions) and life stress (19 questions).

Affective variables measured in an evaluation given upon completion of the workshop were parent’s comfort level and likelihood of using these new techniques outside of the clinical setting due to practice effects.

**Procedures**

*Baseline:* On the first day of the study, parents were asked to sign an Institutional Review Board (IRB) consent form (Appendix A), and a video consent form (Appendix B). Upon completion of consent forms, participants were then asked to complete a behavior questionnaire (Appendix C) regarding their child’s behavior, and the PSI domains (Appendix D) regarding their ratings of depression, competence and life stress. Finally, and beginning each consecutive day of baseline thereafter, parents were asked to role-play a scenario in the typical manner that it would be addressed in their home environment. The instructor reiterated privacy and confidentiality agreements, and assured parents that their responses did not affect their workshop certification; therefore, they were encouraged to use any type of discipline such as spanking, changing tone of voice or facial response, physical guidance etc., they would normally use with their child. Since all four participants attended solo (not as part of a couple), the instructor played the
part of the child. If a couple had volunteered, one of the parents would have played the part of the child.

_Treatment:_ This intervention gave each parent a minimum of 2 weeks of treatment. Employing modeling and role-playing, treatment was a simulation of a problematic parent-child scenario as per Edgar Dale’s definition of active participation – “…doing a dramatic presentation, simulating the real experience, doing the real thing…” (1969). Six different scenarios were developed based on participant’s real-life, common problematic parent-child interactions in an attempt to “train diversely,” arranging for each parent to employ skills with a variety of potential problematic behaviors (Stokes & Osnes, 1989). Diverse training is important to establish a generalized behavior change and for promoting parental adherence outside of the clinical setting (Stokes & Osnes, 1989). Problematic parent-child interactions were developed according to the workshop’s historical data of parental indication of problematic areas, and in concordance with the video demonstrations viewed during the “Winning at Parenting” workshop. The scenarios encompassed a wide age range from toddler to 17 years old. The scenarios were presented in randomized order, but in the same order for each participant. Randomization was determined from a table of random digits (Wallis & Roberts, 1956). The instructor verbally explained the literature supporting the behavioral parenting techniques, and then modeled appropriate and expected parental behaviors while role-playing a scenario with the parent acting as the child. Parents were able to play the part of their child, enabling them to portray the disruptive behavior as accurately or as disruptive as they wished, and could then see a model exhibit appropriate behavioral parenting skills to deal with such behavior. This was followed by a role-reversal in
which the instructor played the part of the child acting disruptively and the parent was given the opportunity to employ the behavioral techniques to address such behavior. (If a parent dyad had volunteered then each parent would have rotated playing the part of the child.) The instructor immediately provided performance feedback to the parents - positive reinforcement for correct demonstrations and corrective feedback for skill improvements - and answered any questions. After each role-play completion, the parent was always given an opportunity to ask questions, discuss what had happened, and discuss similar experiences outside of the clinical setting. The theory of “extinction burst” (see generalization) was also explained to the parents, and they were told to expect this at home and realize it was a sign that they were effectively employing their new parenting skills. Finally, parents were given reference cards called “MyTell” cards with written and illustrative reviews of the behavioral skills to take home.

Scenarios focused on clear communication, and parental use of differential attention and compliance training utilizing a mild restrictive procedure such as time-out. The following were two examples of scenarios managing various age groups. For an extensive list of scenarios see Appendix G.

SCENARIO 1: Your child (applies to school aged through adolescent) is responsible for taking out the trash after dinner on Sundays and Wednesdays. For various reasons, he never seems to complete his chore and you find yourself chasing the garbage man every morning!

PARENT: Jack, (awaiting eye contact) I need the trash taken out to the curb before you continue playing your video game. Now, please repeat to me what I need done.
CHILD: Aaah Mom, why do I have to take out the trash? Why can’t Trish. I hate the smell of it, it makes me want to hurl. (Parent does not engage in verbal interaction [ignoring], merely waits for appropriate response.) Fine, whatever, I’ll do it later. (Child continues to play video game.)

PARENT: Jack, I need the trash taken out to the curb before you continue playing your video game. Now what do I need?

CHILD: You need me to take out the trash.

PARENT: I need you to take the trash out to where and before when?

CHILD: You need me to stop playing my video game and take the trash out to the curb.

PARENT: You said it, Thanks!

It is important that the child repeats all aspects of the request, thereby accepting full responsibility. If child continues to play video games, nonexclusion time-out begins. The timeframe for completing the request is up to the parent. If the agreement was that the trash be taken out before the child goes to bed, then the parent is instructed to not mention this chore ever again for the rest of the evening – they no longer own this problem, ownership has been transferred to the child. After the child has gone to bed, if the chore has not been completed the parent is instructed to calmly and gently awaken the child. Using limited words remind the child of his chore for example: “Jack, the trash.”

SCENARIO 2: Your child (applies to toddler through preschool) always begs you to let them walk instead of riding in the cart at the grocery store. However, every time you give in they take off running up and down the aisles, touching everything!
PARENT: (Prior to letting them out of the car) Billy, today you may walk beside
Mommy’s cart. I will not allow running. (Upon selecting a cart, prior to
entering the store). Billy, no running. You may walk beside Mommy or sit in
the cart, you decide.

CHILD: I want to walk with Mommy.

Parent is instructed to immediately begin engaging the child in shopping for example:
“I’m looking for apples. Tell me when you see them.” Once the child spots the apples,
parent is instructed to immediately praise them and repeat the process. If the child does
not comply and begins to run down the aisle, parent is instructed to immediately grab the
child and say…

PARENT: “You have decided to sit in the cart.” (while sitting them in the cart)
CHILD: (Crying, screaming, kicking…) No, Mommy! I’ll walk, no cart!

Non-exclusion time-out begins (contingent observation), where the parent withholds eye
contact and verbal interaction (ignoring) until the inappropriate behavior subsides for
determined amount of seconds. If tantrum continues excessively, parent is instructed to
explain time-out rules (when it begins, behavior expected during, when it will end).
Once inappropriate behavior subsides for predetermined amount of seconds (5-30), the
steps are repeated allowing the child to make amends having experienced both positive
and negative consequences.

Generalization

Six scenarios were developed based on common problematic parent-child
interactions in an attempt to “train diversely” – employ sufficient stimulus exemplars and
response exemplars (Stokes & Osnes, 1989). The present study arranged for each parent
to employ their new behavioral skills with a variety of child behaviors in a variety of scenarios as a strategy to establish a generalized behavior change and promote parental adherence to training outside of the clinical setting (Stokes & Osnes, 1989). Sufficient exemplars were critical because if the stimulus class was too narrow, parents may not adhere to treatment outside of the clinical setting (Stokes & Baer, 1977). Allen and Warzak (2000), suggested three strategies to strengthen generalization and parental adherence:

(1) “…arrange a variety of training conditions, which might involve rehearsing new parent behaviors… in a variety of everyday conditions”;

(2) “incorporate salient stimuli that can be present in training and nontraining conditions, which might involve… reviewing a simple list of intervention steps during training…” and giving it to the parent for review outside of the clinical setting (e.g., post it on the wall or refrigerator); (3) “incorporating salient self-mediated discriminative stimuli that can be maintained and transported by the parent as a part of treatment…” (e.g., parents carry discriminative stimuli on a keychain with intervention steps).

In a study by Lowry and Whitman (1989), parental adherence and generalization were addressed by training parents to recognize multiple target behaviors in their infants. However, the study only measured parents’ knowledge of relevant target behaviors rather than the parents’ actual behavior toward those target behaviors. The present study trained parents to be aware of a variety of child behaviors and reactions (e.g. the 3 cons), as well as controlling their own behavior and reactions toward those child behaviors by rehearsing clear communication, differential attention and time-out procedures during
role-plays of various everyday situations. Measurements of the parents’ actual behavior during role-plays were collected throughout baseline and treatment to demonstrate the acquisition of skills. Treatment sessions also included use of “MyTell” cards as salient self-mediated discriminative stimuli, which could then be present outside of the clinical setting, in an attempt to program for stimulus generality. “MyTell” cards served as protocols for the parent to follow treatment directives in the absence of the instructor. “MyTell” cards also described low-cost or no-cost activities parents can play with their child that not only instill and build upon their newly acquired skills, but also encourage parental involvement in activities with the child and family connectedness, as well as positive parent-child interactions. As Allen and Warzak suggested, “…look beyond the contingencies that control the behavior of the child and look at those that control the behavior of the parent” (2000).

In addition, in an analysis of the contingencies that affect adherence, Allen and Warzak (2000) proposed defining and warning parents of extinction burst of noncompliant behavior once they begin employing their new parenting skills. Extinction burst is defined as an increase in undesirable behaviors during extinction (Martin & Pear, 1999). Explaining this process to parents during treatment served as an establishing operation because it “establishes the reinforcing effectiveness of a consequence and also evokes behaviors that have been reinforced by that consequence” (Allen et al., 2000). In other words, it changed what functioned as reinforcement for the parent. Furthermore, when the instructor played the part of the child, portrayal of intense disruptive and noncompliant behavior was used in an attempt to employ sufficient stimulus exemplars and response exemplars toward extinction bursts (Stokes & Osnes, 1989).
This study was designed based upon the review of literature demonstrating that behavioral techniques such as differential attention and time-out procedures do improve maladaptive child behaviors. Although the parents were warned of extinction bursts, the premise was that once the parent implemented the behavioral skills at home and the child responded appropriately, the parent would be reinforced and treatment effects would maintain. Wolf (1978) suggested that part of the parent’s reinforcement is their perception of the change in their child’s behavior; consequently, the more the parent is reinforced, the higher the probability of adhering to the intervention strategies learned and maintaining long-term treatment effects. In addition, Stokes and Osnes (1989) suggested that functional contingencies employ natural consequences and reinforcers. Both parent and child come into contact with natural consequences and reinforcers when skills of clear communication, differential attention, and time-out procedures are employed. It was predicted that the parent would gain their child’s compliance toward requests; the child would gain positive attention from the parent when they complied; and negative parent-child interaction would be kept at a minimal. The positive attention may act as a natural reinforcer for the child, promoting compliance with future requests in order to gain further positive attention. What's more, studies have shown that treatment effects can generalize to improvements in the behavior of other children in the home (e.g. siblings) (Eyberg & Robinson, 1982; Kalb & Loeber, 2006; Rhule, McMahon & Spieker, 2004). Antecedents, responses, and consistent consequences may impact the amount, length, and intensity of behavior exhibited (Stokes & Osnes, 1989).
Social Validity

This study endeavored to change ineffective parenting practices by teaching court-ordered and voluntary parents strategies to effectively communicate, interact, and establish consequences with their children in order to gain and maintain compliance. This was of social importance because dysfunctional parenting practices and parent-child interactions are predictive of disruptive behaviors in children that persist over time. “Disruptive behaviors are often stable and predictive of negative mental health outcomes ranging from school failure to substance abuse and criminality” (Stormshak et al., 2000). Parenting practices and parent-child interactions are an essential component in identifying, assessing, and implementing a child’s mental health treatment. Overall, parent training has been empirically found to reduce children’s maladaptive behaviors. Also of social importance, new research is beginning to demonstrate generalized changes from parent trainings such as decreased parental stress and increased sense of competence (Feinfield & Baker, 2004). Social validity was evaluated by satisfaction ratings included in the treatment evaluation form (Appendix H), administered on the final day of the study. Questions addressed the relevance and usefulness of the treatment techniques, appropriateness of the treatment procedures, and significance of the treatment effects.
Chapter Four

Results

Direct Observation of Parents Demonstration of Target Behaviors

The present study evaluated the efficacy of employing modeling and role-playing to enhance skill acquisition in an existing parent training program. Within a multiple baseline design, baseline phases lasted 2-4 sessions prior to implementation of the treatment phases, which lasted 2-4 sessions. Data gathered by direct observation in a clinical setting, and parental ratings of their child’s behavior, parental sense of competence, parental depression and life stress are presented below.

Comparison of Each Target Behavior for Each Parent

Data were analyzed according to mean, level and trend of data across baseline and treatment phases. There was clearly a mean increase in correct demonstration of each target behavior for each parent only after the treatment condition was introduced, indicating a significant treatment effect (see Table 1). Furthermore, because there was no overlap of data points from baseline to treatment, changes in level were evident, providing a strong case that behavior was changed due to treatment effects. Although trend of the behaviors in baseline varied, data points in the treatment phase for each target behavior for each parent made such a dramatic and immediate jump, that they each were indicative of a treatment effect. Trend of behavior will be discussed per individual.
Table 1. Mean Percentage of Each Skill Demonstrated for Baseline and Treatment Phases

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sylvia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Communication</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Differential Attention</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Time-Out Procedures</td>
<td>10%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Ivy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Communication</td>
<td>55%</td>
<td>100%</td>
</tr>
<tr>
<td>Differential Attention</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Time-Out Procedures</td>
<td>0%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Alice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Communication</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Differential Attention</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>Time-Out Procedures</td>
<td>0%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Mickey</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear Communication</td>
<td>33%</td>
<td>100%</td>
</tr>
<tr>
<td>Differential Attention</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>Time-Out Procedures</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Overall Level of Behavioral Parenting Skills Demonstrated

Figure 1 shows the effects of the treatment on the overall level of behavioral parenting skills demonstrated (out of 10 possible skills), by the four participants within the multiple baseline design. Baseline measures show zero trends with high stability. The mean percentage of overall skills demonstrated during baseline was 20% for Sylvia, 17% for Ivy, 20% for Alice, and 13% for Mickey. Baseline observations during role-plays revealed low rates of clear communication, differential attention, and time-out procedures for all participants.

According to the multiple baseline across participants design, the demonstration of parenting skills increased immediately upon implementing treatment and remained at levels significantly higher than those of baseline observations throughout the remainder of the treatment phase. Furthermore, because there was no overlap of data points from baseline to treatment, changes in level are evident, providing a strong case that behavior was changed due to treatment effects. The mean percentage of overall skills demonstrated after treatment was 98% for Sylvia, 90% for Ivy, 90% for Alice, and 100% for Mickey. Overall, these data demonstrate positive treatment effects.
Figure 1. The Percentage of Overall Parenting Skills Demonstrated
Individual Data

Results for Sylvia are shown in Figure 2. During baseline Sylvia had a mean of 50%, with a downward trend in the demonstration of clear communication skills. Sylvia demonstrated zero skills of differential attention, and a mean of 10% for time-out procedures during baseline. Prompt changes were seen with the introduction of treatment. On the first treatment session, Sylvia demonstrated 100% of clear communication and differential attention skills, and 80% performance of time-out procedures. During the remaining 3 weeks of intervention, Sylvia performed all behavioral parenting skills at 100%, presenting a zero trend line with high stability. There was no overlap of data points between the two conditions, demonstrating an evident change in both mean and level.
Figure 2. Individual Data for Sylvia.
Results for Ivy are shown in Figure 3. During baseline Ivy had a mean of 55% in the demonstration of clear communication skills, with a gradually increasing trend. Ivy demonstrated zero skills of differential attention and time-out procedures during baseline. Prompt changes were seen with the introduction of treatment. On the first treatment session, Ivy demonstrated 100% of clear communication and differential attention skills, and 80% performance with time-out procedures. During the remaining 2 weeks of intervention, Ivy performed both clear communication and differential attention skills at 100%, presenting a zero trend line with high stability. Ivy’s demonstration of time-out procedures dropped on week 5 down to 60%, but ended week 6 on an upward trend of 100%. Overall, Ivy went from a mean of 0% demonstration of time-out procedures during baseline, to a mean of 80% performance during the treatment condition. There was no overlap of data points between the two conditions, showing an immediate and evident change in both mean and level; thus, strongly indicative of a treatment effect.
Figure 3. Individual Data for Ivy.
Results for Alice are shown in Figure 4. During baseline Alice had a mean of 50%, showing a zero trend with high stability in the demonstration of clear communication skills. Alice had a mean of 25% in the demonstration of differential attention skills, and zero skills with time-out procedures during baseline. Prompt changes were seen with the introduction of treatment. With just one treatment session Alice demonstrated 100% of clear communication and differential attention skills, and a mean of 80% performance with time-out procedures. During the final week of intervention, Alice’s performance with both clear communication and differential attention skills remained stable at 100%, and demonstration of time-out procedures also remained stable at 80%. There was no overlap of data points between the two conditions, presenting an immediate and evident change in both mean and level; thus, strongly indicative of a treatment effect.
Figure 4. Individual Data for Alice.
Results for Mickey are shown in Figure 5. During baseline, Mickey had a mean of 33%, with a rapidly decreasing trend in the demonstration of clear communication skills. Mickey demonstrated 50% of differential attention skills on only one day during baseline, but the stable trend was at zero resulting in a mean of 13% performance. Similarly with time-out procedures, Mickey demonstrated 20% of time-out procedures on only one day during baseline, but the stable trend was at zero resulting in a mean of 5% performance. With just two days of intervention Mickey demonstrated 100% of clear communication skills, differential attention skills, and time-out procedures. There was no overlap of data points between the two conditions, showing an immediate and evident change in both mean and level; thus, strongly indicative of a treatment effect.
Figure 5. Individual Data for Mickey.
Inter-Observer Agreement

Inter-observer agreement (IOA) data were collected and assessed on each observation session distributed across the baseline and treatment sessions for each participant. Measurements were taken on occurrence and nonoccurrence of each of the ten target behaviors. The overall mean percent IOA score for the four participants ranged from 90% to 93%. Percentage of agreement was the number of agreements out of ten possible skill demonstrations, divided by 10 and multiplied by 100. Table 2 shows the mean percent IOA scores for each participant. Checks on observer reliability were implemented on 33% of the observation sessions for each participant. Following the process of random selection written by Wallis and Roberts (1956), out of the six sessions per participant, one session was chosen at random from baseline and one chosen at random from treatment for each participant using a table of random digits.

Table 2. Mean Percentage of Inter-Observer Agreement Scores for All Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylvia</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>70%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Ivy</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
<td>70%</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Alice</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>70%</td>
<td>93%</td>
</tr>
<tr>
<td>Mickey</td>
<td>90%</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
<td>92%</td>
</tr>
</tbody>
</table>
Parent Rating Scales

Behavior Questionnaire for Parents

The behavior questionnaire for parents was designed to compile information on the child’s behavior in common problematic areas to enhance the accuracy of portrayal during role-plays, and measure changes in the child’s behavior following treatment given to the parent. During the treatment phase, participating parents were asked to practice their new skills outside of the clinic with their child. Scores were reported by the mean percentage per category, and the mean percentage overall. There was an overall mean shift from 50% pre-treatment down to 46% post-treatment, representing a reduction in problem behavior. Table 3 presents the results.

Prior to treatment, Sylvia had the highest mean percentage (out of all the participants) for her child’s behavior - 27%. Following treatment, Sylvia’s behavior ratings for her child resulted in a mean shift down to 25%, showing a decrease in behaviors exhibited by her child.

Prior to treatment, Ivy’s mean percentage for her child’s behavior was 17%; and following treatment that mean shifted up to 19%, showing a slight increase in behaviors.

Prior to treatment, Alice had the second highest mean percentage for her child’s behavior - 26%. Following treatment, Alice’s mean percentage shifted down to 18%, showing a decrease in behaviors. This was the largest reduction in mean percentage of a child’s behavior from all participants – 8%.

Prior to treatment, Mickey had the lowest mean percentage for her child’s behavior - 11%. Following treatment, Mickey’s mean percentage for her child’s behavior shifted up to 12%, showing an increase in behavior.
Table 3. Mean Percentage of Scores on the Behavior Questionnaire for Parents

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>Sylvia</td>
<td>13%</td>
<td>7%</td>
<td>13%</td>
<td>53%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>62%</td>
<td>7%</td>
<td>13%</td>
<td>Overall Mean</td>
</tr>
<tr>
<td>Ivy</td>
<td>27%</td>
<td>13%</td>
<td>33%</td>
<td>33%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>42%</td>
<td>47%</td>
<td>Overall Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alice</td>
<td>7%</td>
<td>47%</td>
<td>27%</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>45%</td>
<td>Overall Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mickey</td>
<td>93%</td>
<td>87%</td>
<td>7%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Parenting Stress Index (PSI)

The PSI was an assessment tool utilized to measure a parent’s level of competence, depression, and life stress prior to treatment and following completion of treatment. It was not administered in the standardized way, as a complete set of questions. There were no clear trends in the results. Table 4 presents the results of each participant’s PSI assessment.

Although both scores for the competence index and depression index fell within normal limits both pre- and post-treatment, Sylvia’s competence index score increased and the depression index score decreased upon completing her treatment. Sylvia was the only participant whose life stress index score fell in the clinically significant range both pre- and post-treatment. The life stresses for Sylvia prior to treatment were: separation, moved to new location, entered new school, and legal problems. Although it remained in the clinically significant range following completion of treatment, it decreased by one. The life stresses for Sylvia following treatment were: income increased substantially (20% or more), moved to new location, began new job, trouble with teachers at school, and legal problems.
Although all scores fell within normal limits pre- and post-treatment, Ivy’s competence index, depression index, and life stress index scores all decreased upon completion of her treatment. The life stresses for Ivy prior to treatment were: went deeply into debt, income decreased significantly, entered new school, and trouble with teachers at school. Ivy is the only participant to score a 0, implying no life stresses post-treatment.

Although Alice’s competence index and depression index scores fell within normal limits pre- and post-treatment, Alice’s competence index score decreased upon completion of her treatment, and her depression index score increased upon completion of her treatment. The life stress index score fell within normal limits prior to treatment for Alice, but increased to the clinically significant range post-treatment. Alice’s life stresses prior to treatment were: went deeply into debt, income decreased substantially, and legal problems. The life stresses for Alice post-treatment were: went deeply into debt, income decreased substantially, alcohol or drug problem, and legal problems.

Although all scores fell within normal limits, Mickey’s competence index and depression index scores both increased upon completion of the study, and the life stress index score decreased upon completion of the study. Mickey’s life stresses prior to treatment were: pregnancy, promotion at work, and legal problems. Mickey’s life stresses post-treatment were: pregnancy, and promotion at work.
Table 4. Raw Scores of PSI Parent Domain Measures

<table>
<thead>
<tr>
<th></th>
<th>Competence</th>
<th>Depression</th>
<th>Life Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>Sylvia</td>
<td>29</td>
<td>32</td>
<td>22</td>
</tr>
<tr>
<td>Ivy</td>
<td>28</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Alice</td>
<td>30</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Mickey</td>
<td>17</td>
<td>20</td>
<td>12</td>
</tr>
</tbody>
</table>

* Identifies raw scores in the clinical range

Social Validity

Social validity was assessed by satisfaction ratings included in the evaluation form of the treatment study (see Appendix H). The evaluation form was administered to the participants on the final day of data collection. Questions addressed the relevance and usefulness of the treatment techniques, appropriateness of the treatment procedures, and significance of the treatment effects. Table 5 presents overall mean percentages of satisfaction with treatment as rated by participants.

There was a unanimous agreement that the extra role-play sessions helped them learn the parenting skills discussed during the workshop; and all but one participant recommended that these extra sessions of role-playing scenarios be included in future “Winning at Parenting” workshops.

The participants also unanimously agreed that the behavioral parenting skill of Ignoring was most useful, followed by equal approval for both Clear Communication and Positive Attention. Time-Out was considered the least useful.
Using a 7 point Likert-style scale in which a score of 1 indicated “least likely to use this skill in the future” and a score of 7 indicated “most likely to use this skill in the future” the following are the results per participant.

Sylvia was most likely to use Clear Communication, Positive Attention and Ignoring in the future, giving all three parenting skills the highest rating of a 7. For Sylvia, Time-Out would be the skill least likely to be used in the future giving it a rating of a 2.

Ivy was most likely to use Positive Attention and Time-Out giving them both the highest rating of a 7, followed by Clear Communication with a rating of a 6. For Ivy, Ignoring would be the skill least likely to be used in the future giving it a rating of a 5.

Alice was most likely to use Clear Communication, Positive Attention and Ignoring giving these three skills a rating of 6; and least likely to use Time-Out giving it a rating of 4.

Mickey was most likely to use all four parenting skills learned and rated Clear Communication, Positive Attention, Ignoring and Time-Out with the highest score of a 7.

The social validation data showed that parents were satisfied with the relevance and usefulness of the treatment techniques, appropriateness of the treatment procedures, significance of the treatment effects, and outcomes of the treatment program.
Table 5. Parental Ratings of Overall Satisfaction with Treatment

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel the extra role-play sessions helped you learn the parenting skills discussed?</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Would you recommend these extra sessions of role-playing scenarios be included in future Winning at Parenting workshops?</td>
<td>75%</td>
<td>25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which parenting skills from the role-play sessions have you tried using?</th>
<th>Clear Communication</th>
<th>Positive Attention</th>
<th>Ignoring</th>
<th>Time-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
</tr>
</tbody>
</table>

| Please check each parenting skill you found to be most useful.             |                    |                   |          |          |
|                                                                          | 75%                | 75%               | 100%     | 25%      |

| Please check each parenting skill you found to be least useful.             |                    |                   |          |          |
|                                                                          | 0%                 | 0%                | 0%       | 50%      |

| What is your comfort level with using the following parenting skills?       |                    |                   |          |          |
|                                                                          | 75%                | 85%               | 82%      | 69%      |

| What is the likelihood that you will continue to use this skill in the future? |                    |                   |          |          |
|                                                                          | 93%                | 96%               | 89%      | 71%      |

* Additional Comments:
  1. "Role-playing scenarios were very effective."
  2. "I love the classes. At first I thought they were going to be boring. I was wrong."
  3. "She [instructor] really help me to be a better parent. I thank her a lot for taking her time and teach us. Thank you."

* Instructor's overall mean percentage rating for being helpful was 96%. 
Chapter Five

Discussion

The purpose of this study was to advance our knowledge regarding the effects of modeling, role-playing and feedback used to increase adaptive parenting skills of participants attending the parent workshop called “Winning at Parenting.” “Winning at Parenting” is a predominantly lecture-style workshop. To supplement “Winning at Parenting,” each night before the workshop began the instructor (a graduate student) met individually with volunteer parents to model and role-play behavioral parenting skills. These individual sessions were meant to engage the parent in active learning as a means to increase their knowledge, comfort level, and likelihood of using the adaptive parenting skills taught in the workshop. It was hypothesized that despite being superimposed upon an ongoing parenting workshop, significant effects from baseline would not occur until treatment was implemented. Variations in time spent in the workshop were not expected to have a significant impact on baseline measures.

Experimental Control

A multiple baseline design across participants demonstrated the effects of modeling and role-playing in an experimentally controlled manner. By introducing the intervention to a different participant at different points in time, and producing data changes at those specific points in time and not at prior or subsequent times, the experimentally controlled effects were demonstrated.
Two research questions were examined. The first questioned whether participants would increase their use of adaptive parenting strategies (clear communication, differential attention, and timeout) through the use of modeling, role-play and feedback, within the multiple baseline design. The results showed that parents did indeed increase their use of adaptive parenting skills through the use of modeling, role-playing, and feedback from the instructor. There was little to no (0%-30%) demonstration of behavioral parenting skills during baseline measures; but after treatment there was 80-100% demonstration of all parenting skills. These findings are consistent with previous research demonstrating that the use of modeling and role-playing are superior to readings and lecture-style for parent training programs (Brotman et al., 2005; Danforth, 1998; Dumas & Wahler, 1983; Graziano & Diament, 1992; Knapp & Deluty, 1989; O’Dell, 1974; Wahler, 1980). Data were analyzed according to mean, level and trend of data across baseline and treatment phases. Given that there was no overlap of data points from baseline to treatment, changes in mean and level were evident, providing a strong case that behavior was changed due to treatment effects. Although trend of the behaviors during baseline varied, data points in the treatment phase for each target behavior for each parent made such a dramatic and immediate jump (versus gradually), that each were indicative of a treatment effect. The treatment effects were robust even though the didactic program “Winning at Parenting” continued to operate and sporadically introduce skills – the workshop’s sequence of teaching skills was independent of the research study so skills were not taught on the same days. Appropriate parenting skills were only demonstrated at 100% when treatment was implemented, showing that practice effects and active learning affected the acquirement of skills.
The workshop’s agenda is a key component in analyzing the results of this study because it accounts for other independent variables that may have caused any behavior change. The following describes the workshop’s agenda. On week one, the “Winning at Parenting” workshop instructor lectures on discipline, informs parents that spanking is the least effective means of discipline, and discusses alternative means of discipline such as time-out, and conflict resolution using negotiations and behavioral contracts. On week two, the workshop instructor lectures on ineffective communication and ways to communicate effectively such as eye contact and using more details in a request. Also, parents are asked to write down one specific problem they are concerned about with their child and would like the workshop instructor to respond with parenting suggestions. On week three, the workshop instructor reviews these effective communication skills and introduces active listening using “you feel…” statements. Active listening reflects the child’s feelings and lets the child know they are being heard, the parent is paying attention and understands. On week four, the workshop instructor continues lecturing on effective communication skills and begins engaging parents in role-plays utilizing “you feel…” statements. For example, two participants are asked to come to the front of the room and sit in chairs facing each other. One parent is asked to act as a child upset about something (school, something the child wants, etc.). The other participant plays the part of the parent actively listening, and is to reflect the feeling conveyed by the upset child by using a “you feel…(frustrated, disappointed, etc.)” statement. That completes the role-play, with the workshop instructor providing feedback. Then the participants switch roles and the process is repeated, with the workshop instructor providing feedback again. On week five, the workshop instructor begins lecturing on “I-messages.” I messages are
a means to effectively communicate a problem the parent has with the child. The workshop instructor covers skills such as giving direct requests in statement form (not posed as a question), giving details and not assuming the child knows, and the importance of eye contact. Conflict resolution is also discussed again, and the lecture is followed by participants being asked to engage in role-plays utilizing “I-messages” and contract negotiations. These scenarios consist of one participant acting as the child, and the other acting as the parent approaching the child with a problem such as taking the trash out, completing homework, etc. The parent is to express their problem by saying, “I feel…(the trash needs to be taken out before you go to bed). What can I do to help get this chore done?” Then the participants pretend to negotiate and write-up a contract expressing the child will do “X” the parent will do “Y” or else “Z” will happen. That completes the role-play, with the workshop instructor providing feedback. Then the participants switch roles and the process is repeated, with the workshop instructor providing feedback again. On week six, any participant that has not engaged in a role-play takes their turn. After all parents have participated in a role-play, the workshop instructor addresses the parents’ specific child problems they submitted during week two. During this advise session, the workshop instructor reviews skills of clear communication, differential attention and time-out, among other suggestions given.

Knowing the workshop’s agenda and looking at the graphical representation of data from the study, it was evident that the sequence of disseminating knowledge during the workshop was independent of the implementation of treatment; and that despite the week a parent received treatment, only when they received treatment did they demonstrate appropriate parenting behavior in a role-play scenario. During weeks one
and two of the workshop clear communication skills are discussed, and although 2 out of 3 participants in baseline showed some increase in the demonstration of these skills on week three, it was not until the introduction of treatment that they demonstrated 100% of clear communication skills. Furthermore, on week four (after 3 workshop lectures on clear communication skills), data for Alice and Mickey showed a downward trend. Similarly, the workshop instructor lectured on time-out versus spanking beginning on week one, yet 2 out of 4 parents demonstrated zero skills of time-out during the baseline phase of a role-play scenario on week two. The other two parents did show a behavior change on week two, but it was a mere 20% performance of time-out skills. Once again, not until participants were introduced to the treatment phase did they perform time-out skills at 100%. What’s more, Ivy actually continued to use spanking during baseline despite the workshop lecture. It was not until Ivy entered the treatment phase that she discontinued using spanking as a means to discipline.

When comparing graphs of clear communication, differential attention, and time-out skills side-by-side, the didactic workshop does have an effect on clear communication. Notice in Figure 6 that the baseline conditions of differential attention and time-out skills have multiple data points at zero, but clear communication shows nearly no data points at zero. Each parent did demonstrate some percentage of clear communication skills prior to treatment. This could have very well been due to the lectures on clear communication of the ongoing workshop. Nevertheless, only after the implementation of treatment did the participants demonstrate 100% of clear communication skills.
Figure 6. Side-by-Side Comparison of Data Graphed for Clear Communication, Differential Attention, and Time-Out Skills.
The second research question was whether parent’s ratings of competence, depression, and life stress changed as a result of the intervention using modeling, role-play and feedback. The results were not as clear for the effects of treatment implementation on these PSI scores. There were no obvious trends in the data. The reviewed literature suggested that improved parenting practices would mediate child behavior problems, and child improvements would mediate positive changes in parental attitudes and stress (Feinfield & Baker, 2004; Pennington-Peters, 1998). Only one participant in the present study showed results consistent with the literature – Sylvia’s competence index score increased following treatment; her scores on the depression index decreased following treatment; and although remaining in the clinically significant range, her life stress index decreased following treatment as well. Contrary to the reviewed literature, 50% of participants in the present study had reductions in the competence index scores, and a rise in the depression index scores. A speculated reason could be that parent’s felt more comfortable completing the assessment honestly, revealing more upon completion of the treatment. Also, six weeks may not be sufficient time to measure these PSI components. Another speculation could be that while the instructor (acting as the child) portrayed intense disruptive behaviors for the parents during role-play to prepare parents for extinction bursts, such intense behavior actually made parents second guess their ability to handle such behavior. At one point during the study, a parent stated that she didn’t know if she could handle a situation so intense. The instructor replied, “You just did!” (On a side note, such positive reinforcement from the instructor can increase generalization and adherence outside of the clinical setting.)
As for the life stress index, a distinction should have been made regarding child-related life stresses because while 75% of participants in the present study reduced their overall score on the life stress index, specific child-related stresses suddenly appeared during post-treatment assessment that were not identified by the parent prior to treatment. An increase in child disruptive behaviors could have very well been due to the parent’s implementing their new behavioral skills, though this is merely speculation. Once again, six weeks may not have been sufficient time to measure these PSI components.

Additionally, the reviewed literature emphasized the following three primarily important reasons for incorporating alternative discipline techniques during parent training programs: (1) parental positive reinforcement alone showed to be insufficient in altering deviant behavior specifically with clinic-referred youth; however in conjunction with time-out deviant behavior was altered (Forehand, 1986); (2) time-out was found to be effective “independent of other parental effects such as attention” (Kalb & Loeber, 2006); and (3) corporal punishment repeatedly showed to be a strong and stable predictor of disruptive behavior in youth (Frick, Christian & Wootton, 1999). Instructing parents how to correctly employ time-out, utilizing all five vital steps, showed to be beneficial to this study. Anecdotally, the one participant that used spanking during the baseline phase, never once used (nor hinted at the use of) spanking during the treatment phase – without ever being told not to use spanking. This was promising considering studies that showed behavioral parent training affected child behavior by changing the parent’s behavior (Feinfield & Baker, 2004). This outcome supported literature affirming that parents can learn to and successfully change their interaction style with their children, and as a result
change the behavior of their children (Brotman et al., 2005; Danforth, 1998; Eyberg, 1988; Eyberg & Robinson, 1982; Feinfield & Baker, 2004).

**Generalization**

Six scenarios were developed based on real-life and common problematic parent-child interactions in an attempt to “train diversely” (Stokes & Osnes, 1989). Parents were able to play the part of their child enabling them to portray their child’s behavior as accurately and intensely as they wished to see a model of behavioral parenting skills with such behavior. This was followed by a role-reversal in which the instructor played the part of the disruptive and noncompliant child, and the parent was given the opportunity to employ the behavioral techniques with such behavior. The present study trained parents to be aware of a variety of child behaviors (including the 3 cons), as well as controlling their reactions toward those child behaviors by practicing clear communication, differential attention and time-out procedures during role-plays. This study established generality to other individuals by replicating the study with multiple participants with dissimilar characteristics – differences in age, race, education level, age of child, (just to name a few). It increased the probability of generalization by utilizing techniques that: were simple to learn and to implement within natural everyday parent-child interactions; employed natural consequences and reinforcers for both parent and child; and did not require additional materials. In terms of the generality of a newly learned behavior, by explaining the process of extinction bursts of noncompliant behavior to the participants it changed what functioned as reinforcement for the parent. When the instructor played the part of the child, portrayal of intense disruptive and noncompliant behavior was also an
attempt to employ sufficient stimulus exemplars and response exemplars toward the
warned extinction burst.

Subsequent to the study, two of the participants contacted the instructor (on their
own accord), approximately five weeks after the completion of treatment. Both Sylvia
and Ivy stated that the “MyTell” cards were very helpful, and they had reviewed them
multiple times over the past five weeks. Both participants also reported extinction bursts,
and were thankful for the warning during treatment. Ivy stated that, “It [the
warning/knowing about it] helps me to remain in control during the situation” (personal
communication, March 17, 2006). Ivy also admitted that ignoring was still difficult for
her to employ, but had continued to try. What’s more, Sylvia excitedly said that she
continued to use time-out, and she and her son had never gotten along better! (Sylvia had
noted on her evaluation form that time-out was the skill least likely to be used in the
future.) Sylvia said, “My son and I have gotten into a routine and there’s less fighting
because he now knows I’m going to use time-out, and when he’s in time-out there’s no
more arguing about it; so when he gets out of time-out it’s time to just do whatever I
asked” (personal communication, March 25, 2006). Sylvia and Ivy both expressed their
gratitude for the training, and said what a difference it had made in their interactions with
their child.

Social Validity

Wolf (1978) asserts that the treatment effectiveness is determined by the social
impact of the behavioral treatment. In addition to the positive treatment effects
demonstrated, results from the study’s evaluation questionnaire also supported the social
validity of the treatment. Furthermore, all participants on the final day of data collection
verbally expressed their gratitude for what they had learned, their hopefulness of seeing results at home, and acknowledged the importance of the skills they had learned. In conversation five weeks following treatment, both Ivy and Sylvia stated that they had continued to employ the behavioral techniques and were very satisfied with the results.

**Limitations**

Confounding variables related to measurement of the dependent variables could be the result of observer drift, observer bias, or the influence of the instructor’s behavior on the observer (Cooper, Heron & Heward, 1987). In addition to the major professor, this study enlisted an unbiased third-party, an individual with no applied behavior analysis background and not involved in the study, to score videos in a randomized order based solely on the operationally defined behaviors. By enlisting an observer “blind to the conditions and expected outcomes of an experiment [it] reduces the potential for nonrandom observer error” (Cooper et al., 1987).

Establishing a stable and/or predictable baseline is essential to a multiple baseline design. Demonstration of a functional relationship depends on, “the behaviors still in baseline showing no change in level or trend while behaviors in contact with the independent variable change, and each behavior changing when the independent variable is applied to it” (Cooper, Heron & Heward, 1987). Therefore, baselines that significantly vary in length make a stronger argument. Baseline conditions should also be extended long enough to account for reactivity to measurement procedures. Unfortunately due to the 6-week time constraint of the ongoing workshop, only 2 weeks were allotted for a baseline before implementing the first treatment. One could argue that 2 weeks is not sufficient to achieve fully stable responding. Also, treatment for the second participant
should not have been implemented until stable responding was attained for the first subject, and so on. Nevertheless, due to the extreme change in behaviors once treatment was implemented and not before, this study can confidently state that the effect of the treatment was demonstrated by showing a functional relationship between the behavior change and the introduction of treatment at different points in time.

The use of videotaped role-plays for reliability issues also posed a limitation. There were times when the parent was not facing the camera, or even in the camera’s view range, and other times when the parent was not speaking loudly enough. Although direct observations were not hindered, inter-observer agreement was affected.

Other limitations were the small sample of participants, and participants not randomly selected. The “Winning at Parenting” workshop takes pre-registrations and walk-ins the day of the workshop. Since this study required meeting prior to the start of the workshop, the Children’s Crisis Services provided a list of pre-registered parents that were contacted by telephone prior to the first day of the workshop. Using just the pre-registration list, participants were recruited for the present study. On the first day of the “Winning at Parenting” workshop, the study was announced to all attendees but no other parents volunteered. Consequently, the parents who did volunteer may have been more motivated to learn and change the way they interact versus parents who did not volunteer. A total of 10 parents attended the first night of the “Winning at Parenting” workshop, and of those 10 only 6 received certificates of completion – 4 dropped out. Of the 10 total workshop participants, 5 volunteered for the treatment study and only 1 dropped out.

Despite the demonstration of learned skills and the high satisfaction ratings from the participants, adherence and successful implementation outside of the clinical setting
may be hindered due to lack of a combined parent and child group. Studies that combine parent and child groups have the most improvements in parent-child interactions and child behavior problems (Feinfield & Baker, 2004). Many participants of the “Winning at Parenting” workshop do not have custody of their children. In fact, for many the attainment of a certificate of completion from the workshop is often a means to regain custody of their children.

Adherence and successful implementation outside of the clinical setting may also be hindered due to research stating there is a diminished effectiveness of parent training in relation to the age of the child. “Preschool children (<6 years old) appear to have the highest rates of positive responding to behavioral parent training programs (65% or more); school-age children are somewhat less likely to improve (50-64%); and adolescents are the least likely (25-35%)” (Barkley, Edwards & Robin, 1999). In this study, 2 participants had toddlers, 1 participant had a 13 year old, and 1 participant had a 16-year old. If, as Wolf suggested, a “parent’s reinforcement is their perception of the change in their child’s behavior;” consequently, the less a child’s behavior changes the less the parent is reinforced, the lower the probability of adhering to the intervention strategies learned and maintaining long-term treatment effects (1978).

Despite the successful demonstrations by the parents in this study, some research indicated that stress factors and setting events will hinder maintenance of parenting skills and interfere with these parents becoming successful change agents for their child’s behavior (Bernal, Klinnert, & Schultz, 1980; Dumas & Wahler, 1983; Dumas & Albin, 1986). Stress factors and setting events can include, but are not limited to: parental psychopathology, marital discord, single-parenthood, social isolation, low parental
education, and low socioeconomic status (Dumas et al., 1986). For example, if a couple is in the process of divorcing, and the mother is now experiencing single-parenthood and possibly suffering from depression and/or anxiety attacks, then she may very well be unable to acquire and maintain the skills from a time-limited training. Dumas and Albin suggested that her success may not be a reflection of the adequacy of the training program, but rather mediated by setting events and stress factors (1986). In their conclusion, they predicted that “a time-limited parent training intervention is likely to fail as long as enduring adverse setting events influence family functioning, no matter how actively parents participate in treatment” (Dumas et al., 1986). The PSI indicated that all participants had 3 or more life stressors, and 1 participant had an education level of 8th grade or lower, which increased her risk factor. Accordingly, acquisition and maintenance of behavioral parenting skills may be limited.

Conclusion

Maladaptive behaviors that surface during childhood will resurface in adulthood if untreated; thus, childhood is the preventative stage where intervention should occur. Heavier focus should be placed on preventative measures and early intervention strategies such as parent training programs, to intercede before escalating to an involuntary Baker Act. Positive parenting techniques such as clear communication, differential attention, and time-out procedures are empirically validated techniques that have been employed in many evidence-based treatments. What’s more, they are easy to learn and utilize within natural everyday parent-child interactions, employ natural consequences and reinforcers for both parent and child, and do not require additional materials. Parent training programs, more specifically behavioral parent training
programs, are the most well-researched and empirically proven interventions for children with mental disorders, behavioral disorders, and disruptive, noncompliant behavior (McMahon & Wells, 1998; Kalb & Loeber, 2006). A standard component of all parent training programs should be sufficient time to practice newly learned skills – just disseminating knowledge is not enough. The present study generally supported research stating parent trainings that employ modeling, role-playing and performance feedback will result in better acquirement and demonstration of parenting skills. The effects of behavioral parent training on parental competence, depression and life stress was less obvious, and should be researched further in future studies.

Recommendations for Future Research

Child noncompliance has been documented to be a prevailing problem for parents, and “parent training programs make up the largest and most well-researched interventions for noncompliant children” (Kalb & Loeber, 2006; McMahon & Wells, 1998). Therefore, further research should investigate whether these treatment effects are maintained over time (8 weeks, 6 months, 1 year); and if so, detail how to successfully program for generalization and maintenance. Also essential for future research is whether the child’s disruptive and noncompliant behavior decreases once the parent employs newly acquired skills; and if so, are the effects maintained over time. Treatment effects in regards to different age groups of children should also be investigated since some research suggests there is a diminished effectiveness of parent training in relation to the age of the child. Ultimately, the goal of any parent training is to reduce maladaptive behaviors in children. Unfortunately, this study could not examine the long-term effects of the treatment on neither parent nor child.
Additionally beneficial would be conducting this study with another lecture-style parenting workshop (that does not involve modeling and role-playing of various parent-child scenarios), and comparing those results to the present study. Future studies should also measure the skill performance of participants that complete the parenting workshop, but do not volunteer for the active learning intervention using modeling and role-plays; and compare the results of the two groups of participants.

Finally, it would be both interesting and beneficial to investigate this treatment with volunteer referrals from pediatricians; or where the treatment study is conducted in a pediatric office to patient’s parents. A frequent problem parents approach practitioners with is child noncompliance (Kalb & Loeber, 2006). Kalb et al., suggested that practitioners try “to first introduce some of the basic tips on child discipline… and observe their effectiveness before prescribing more intense parent training” (2006). Unfortunately, many parents do not re-consult with their practitioner if problem behavior persists. Parents are afraid of stigmatizing their child by seeking further therapy, and thus do not pursue help beyond their pediatrician’s basic tips. To this response, the mere distribution of the “MyTell” cards to parents could also be an area for future studies. Many parents of non-clinical referred children may be missing out on the benefits of basic behavioral parent training just because their child’s disruptive and noncompliant behavior is not excessive in intensity, frequency and duration.
List of References


Appendix A

Informed Consent

Social and behavioral Sciences
University of South Florida

Information for People Who Take part in Research Studies

The following information is being presented to you to help you decide whether or not you want to take part in a minimal risk research study. Please read this carefully. If you do not understand anything, ask the person in charge of the study.

STUDY TITLE: The effects of role-playing on the development of adaptive skills in a parent training program

INVESTIGATORS: Chantell Rodriguez, BA and Trevor Stokes, Ph.D

STUDY LOCATION: The Children’s Crisis Services Center

General Information About the Research Study
As a participant in the “Winning at Parenting” workshop you are being asked to volunteer to participate in additional role-play sessions. Two role-play scenarios will be presented each week of the parenting workshop, which operates for six consecutive weeks. We want to find out if participation in additional role-play sessions will help you learn better because you have extra opportunities to practice the parenting techniques.

Plan of Study
During role-play sessions you will be shown parenting techniques and then asked to practice them. During this practice the instructor will talk to you about how well you are doing and possible ways to improve. Assessment will take two to four sessions, and will be conducted by completing questionnaires, by instructor observations, and video recordings observed by a University of South Florida professor.

Description of Procedures
During your first session, we will assess parenting practices, parental stress, parental depression, and parent’s perception of parenting competence by having you complete questionnaires, followed by you role-playing a typical parent-child scenario in the way it would normally occur between you and your child. This session will occur 15-20 minutes before the start of the “Winning at Parenting” workshop.
Appendix A (Continued)

Your second session will involve assessment of a different parent-child scenario for you to role-play in the way it would normally occur between you and your child. This session will occur 10-15 minutes before the start of the “Winning at Parenting” workshop.

Over the following consecutive weeks, for 10-15 minutes prior to the “Winning at Parenting” workshop, we will train you in behavioral parenting techniques, observe and provide feedback on your usage of these techniques, and ask you to practice skills at home.

Training in behavioral parenting techniques consists of an instructor modeling appropriate parent behaviors by role-playing a typical parent-child scenario with you acting as your child. Then you will role-play the scenario again with the instructor acting as your child and you acting as the parent using the new techniques. The instructor will immediately provide feedback regarding your performance, and if necessary describe ways to improve. Treatment will be conducted 10 to 15 minutes prior to the beginning of the “Winning at Parenting” workshop, and will take two to four sessions.

Payment for Participation
There is no charge for participation in this part of the parenting workshop nor will you be paid for your participation in this study.

Benefits of Being a Part of this Research Study
By taking part in this research study you may gain knowledge about better parenting techniques, and may also see improvements in your parenting practices. You will also increase our knowledge on the use of role-playing to better learn parenting techniques, and the need for extra opportunities to practice the new skills.

Risks of Being Part of this Research Study
These assessments and treatments are widely used without harm to parents and families. There are no foreseeable risks to you for participation in this study.

Confidentiality of Your Records
Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, the USF Institutional Review Board and its staff, and any other individuals acting on behalf of USF, may inspect the records from this research project. Records will be kept in locked filing cabinets at the USF Psychological Services Center and will only be viewed by the research team. When results of this study are reported, the identification of all participants will be withheld using instead fictitious first names for questionnaires and observations. The results of this study may be published, however, the data obtained from you will be combined with data from others. No information by which you may be identified will be released or published.

Any information about you and your family will be protected at all times. One exception is if there is any admission of child abuse and/or neglect, the instructor is required by law to report this information to the proper authorities.
Volunteering to Be Part of this Research Study
Your decision to participate in this research study is completely voluntary. You are free to participate in this research study or withdraw at any time. Your participation or withdraw of participation will have no effect upon your participation in the parenting workshop.

Problems or Questions
If you have any questions about this research study contact Chantell Rodriguez (813) 310-0011 or Dr. Trevor Stokes at (813) 974-6189. If you have any questions about your rights as a person who is taking part in a research study you may contact the Division of Research Compliance at the University of South Florida at (813) 974-5638.

Consent to Take Part in This Research Study
You are being asked to provide voluntary and informed consent for your own participation in this study. Your signature shows that we have answered your questions, you agree to participate, and that you have accepted a copy of this form. You may withdraw your consent at any time. The University of South Florida has reviewed and approved this study.

By signing this form I agree that:
• I have fully read or have had read and explained to me this informed consent form describing this research project.
• I have had the opportunity to question one of the persons in charge of this research and have received satisfactory answers.
• I understand that I am being asked to participate in research. I understand the risks and benefits, and I freely give my consent to participate in the research project outlined in this form, under the conditions indicated in it.
• I have been given a signed copy of this informed consent form, which is mine to keep.

Signature of Participant  Printed Name of Participant  Date

Investigator Statement
I have carefully explained to the participant the nature of the above research study. I hereby certify that to the best of my knowledge the participant signing this consent form understands the nature, demands, risks, and benefits involved in participating in this study.

Signature of Investigator  Printed Name of Investigator  Date
Or Authorized Research Investigator designated by
The Principal Investigator
Appendix B

Consent For Videotaping

I ___________________________ agree to be videotaped as part of the research study on “The effects of role-playing on the development of adaptive skills in a parent training program.”

I understand that the researcher(s) in this study will videotape me in order to view my parenting skills. I have been informed that the videotape may be shown to other professionals at research meetings.

__________________________________________  ___________
Signature of Participant                        Date

__________________________________________  ___________
Signature of Investigator                       Date
Appendix C

Behavior Questionnaire for Parents

Child’s Age: _______  Gender: _______  Today’s Date: _______

Form Completed By: __________________________

Please circle the number which best describes your child.

**My child:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Has temper tantrums (crying, screaming, shouting).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2)</td>
<td>Refuses to follow instructions or requests.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3)</td>
<td>Argues when asked to follow instructions or requests.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4)</td>
<td>Needs reminding of daily routines (bathing, chores, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5)</td>
<td>Refuses or argues to go to bed at the scheduled time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6)</td>
<td>Does not stay in bed - comes to your bed during the night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7)</td>
<td>Requires you to lie down with them in bed to fall asleep.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8)</td>
<td>Is difficult to wake up for school in the morning.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9)</td>
<td>Uses physical aggression against parents/siblings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10)</td>
<td>Uses verbal aggression against parents/siblings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11)</td>
<td>Delays or avoids completing homework.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12)</td>
<td>Refuses or argues about completing homework.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13)</td>
<td>Is a picky eater – refuses or argues at mealtime.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14)</td>
<td>Has difficulty sharing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15)</td>
<td>Does not play well with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix D

Parenting Stress Index (PSI)

Instructions:
On the PSI Answer Sheet, please write your name, gender, and age of child or children. Please mark all your responses on the answer sheet.

This questionnaire contains 41 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you Strongly Agree with the statement.
Circle the A if you Agree with the statement.
Circle the NS if you are Not Sure.
Circle the D if you Disagree with the statement.
Circle the SD if you Strongly Disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA A NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. DO NOT ERASE! If you need to change an answer, make an “X” through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS D SD
Appendix D (Continued)

1. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.
2. Being a parent is harder than I thought it would be.
3. I feel capable and on top of things when I am caring for my child.
4. I can’t make decisions without help.
5. I have had many more problems raising children than I expected.
6. I enjoy being a parent.
7. I feel that I am successful most of the time when I try to get my child to do or not do something.
8. Since I brought my last child home from the hospital, I find that I am not able to take care of this child as well as I thought I could. I need help.
9. I often have the feeling that I cannot handle things very well.

For statement 10, choose from choices 1 to 5 below.
10. When I think about myself as a parent I believe:
1. I can handle anything that happens
2. I can handle most things pretty well
3. sometimes I have doubts, but find that I handle most things without any problems
4. I have some doubts about being able to handle things
5. I don’t think I handle things very well at all

For statement 11, choose choices 1 to 5 below.
11. I feel that I am:
1. a very good parent
2. a better than average parent
3. an average parent
4. a person who has some trouble being a parent
5. not very good at being a parent

For questions 12 and 13, choose choices 1 to 5 below.
12. What were the highest levels in school or college you and the child’s father/mother have completed?
   Mother:
   1. 1st to 8th grade
   2. 9th to 12th grade
   3. vocational or some college
   4. college graduate
   5. graduate or professional school
Appendix D (Continued)

13. Father:
   1. 1st to 8th grade
   2. 9th to 12th grade
   3. vocational or some college
   4. college graduate
   5. graduate or professional school

14. When I think about the kind of parent I am, I often feel guilty or bad about myself.
15. I am unhappy with the last purchase of clothing I made for myself.
16. When my child misbehaves or fusses too much, I feel responsible, as if I didn’t do something right.
17. I feel every time my child does something wrong, it is really my fault.
18. I often feel guilty about the way I feel toward my child.
19. There are quite a few things that bother me about my life.
20. I felt sadder and more depressed than I expected after leaving the hospital with my baby.
21. I wind up feeling guilty when I get angry at my child and this bothers me.
22. After my child had been home from the hospital for about a month, I noticed that I was feeling more sad and depressed than I had expected.

For statements 23 to 41, choose from choices Y for “Yes” and N for “No.
In the last 12 months, have any of the following events occurred in your immediate family?

23. Divorce
24. Marital reconciliation
25. Marriage
26. Separation
27. Pregnancy
28. Other relative moved into household
29. Income increased substantially (20% or more)
30. Went deeply into debt
31. Moved to new location
32. Promotion at work
33. Income decreased substantially
34. Alcohol or drug problem
35. Death of close family friend
36. Began new job
37. Entered new school
Appendix D (Continued)

38. Trouble with superiors at work
39. Trouble with teachers at school
40. Legal problems
41. Death of immediate family member
### Appendix D (Continued)

**PSI ANSWER SHEET**

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>NS</th>
<th>D</th>
<th>SD</th>
<th></th>
<th></th>
<th></th>
</tr>
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Appendix E

Target Behaviors

Clear Communication

*Eye Contact*
During role-play, when the parent is making a request for the child to start, continue or discontinue a behavior, they look at the child (role-play therapist) throughout the interaction. When the parent is implementing a restrictive procedure including forms of time-out, they look at the child throughout the interaction.

*Direct Request*
A direct request was given in a statement form, not as a question. During role-play, the parent tells the child what needs to be done, without asking the child if they will do it.

*Detailed Request*
A detailed request gives the child information such as who, what, when, where. For example, “Jack, please take the garbage out to the curb before you continue playing your video game.” The parent may say “you” instead of the child’s name. During role-play, the parent provides the child with details regarding what needs to be done.

Differential Attention

*Attention*
Attention is defined as talk, praise, or affectionate behaviors from the parent that follow the child’s behavior. Talk is defined as conversation with the child or verbal acknowledgement, positive or negative, of the child’s behavior. Praise is defined as positive verbal attention toward the child’s behavior (e.g., good job, etc.), or an expression of approval (e.g., thumbs up, etc.). Affectionate behavior is defined as the parental initiation of positive physical interactions such as a kiss, hug, pat/rub on the back, tickling, etc.

*Providing Attention*
During role-play, the parent provides attention when the child complies with a request. The parent provides attention following desirable behaviors.
Appendix E (Continued)

Withholding Attention
During role-play, the parent withholds attention, physical contact or verbal interaction once undesirable behavior begins. Following a request, the child may attempt to divert attention away from the task by asking moot questions (Why do I have to do it, Why can’t Joe do it, etc.), and/or making irrelevant comments (You’re so mean, None of my friends have to do that, etc.). Parent can withhold attention by either disengaging eye contact, removing one’s self from the presence of the child, remaining silent and/or not attending to the content of the child’s diversion. For example, the parent makes a request, “Jill, I need the trash taken out to the curb before you continue playing your video game.” The child replies, “Why does it have to be done right now, Why can’t Jack do it, That should be a boy’s chore, etc.” The parent remains quiet allowing the child to vent, and when the child pauses the parent restates, “Jill, I need the trash taken out to the curb before you continue playing your video game.” Parent does not answer the moot questions and irrelevant comments, but stays focused on their request.

Time-Out (TO) Procedures

Definition of TO
Time-out is defined as, “The withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified period of time, contingent upon the occurrence of a behavior” (Cooper et al., 1987). Nonexclusion time-out can be ignoring, withdrawal of a specific reinforcer (television or radio turned off, etc.), or contingent observation where the child remains a part of the setting but removed from the ongoing reinforcer. Exclusion time-out is when the child is physically removed from the setting, and placed in a setting devoid of positive reinforcers.

Define Behavior Leading to TO
During role-play, the parent defines for the child what behavior(s) will lead to time-out. Also known as a warning, if they do ‘X’ again they will go to time-out. The actual words time-out are not required. For example, if you do not stop playing your video game I will take it from you until after dinner. Per the definition above, “… the loss of access to positive reinforcers for a specified period of time, contingent upon the occurrence of a behavior” constitutes time-out.
Appendix E (Continued)

Explain TO Rules
During role-play, the parent tells the child when time-out begins and when it will end. This can be as simple as, “Go to _____ (time-out, your room, that chair…) and stay there until I say you may get up” or after taking away a toy saying “you may have this back once you’ve completed my request.” Doesn’t have to be very detailed, as long as child is told what is happening. Parent cannot just tell a child to sit or physically sit the child and walk away – that is not defining what is happening. If child persists to tantrum in time-out, the parent tells the child what behavior is expected in time-out in order for time-out to end. For example: “Your time-out will continue until you stop crying and kicking and calm yourself down.”

Apply TO Consistently
During role-play, the parent applies time-out when the child does not comply with their request. If the child let’s himself out of time-out, the parent re-starts time-out. If the parent has to remind the child of expected behaviors in time-out, they either re-start time or extend time. If a child completes their time-out and parent releases them, but they continue to not comply with parent’s request, the parent applies time-out again.

Ignoring Child in TO
Ignoring behavior is defined as withdrawing attention, physical contact or verbal interaction once undesirable behavior begins. Parent can ignore by either disengaging eye contact, removing one’s self from the presence of the child, and/or remaining silent not engaging in conversation (discussion, reasoning, argument).

Reinforce Appropriate Behavior After TO
During role-play, once the child completes time-out and decides to comply with parent’s request, the parent provides attention to the desired behavior. The parent provides attention to maintain this desired behavior.
Appendix F

Behavior Checklist

Clear Communication

_____ eye contact

_____ a direct request in statement form, not a question

_____ a detailed request (who, what, where, when)

Differential Attention

_____ providing attention to increase desirable behavior

_____ withholding attention to decrease undesirable behavior

Time-Out Procedures

_____ define to child what behavior will lead to TO

_____ explain TO rules (when it begins, expected behavior during, when it ends)

_____ apply TO consistently

_____ absolutely ignoring child in TO

_____ reinforce appropriate behavior upon termination of TO
Appendix G

Role-Play Scenarios

**SCENARIO 1:** Your child (applies to school-age through adolescent) is responsible for taking out the trash after dinner on Sundays and Wednesdays. For various reasons, he never seems to complete his chore and you find yourself chasing the garbage man every morning!

PARENT: Jack, (awaiting eye contact) I need the trash taken out to the curb before you continue playing your video game. Now, please repeat to me what I need done?

CHILD: Aaah Mom, why do I have to take out the trash? Why can’t Trish. I hate the smell of it, it makes me want to hurl. (Parent does not engage in verbal interaction [ignoring], merely waits for appropriate response.) Fine, whatever, I’ll do it later.

PARENT: Jack, I need the trash taken out to the curb before you continue playing your video game. Now what do I need?

CHILD: You need me to take out the trash.

PARENT: I need you to take the trash out to where and by when?

CHILD: You need me to stop playing my video game and take the trash out to the curb.

PARENT: You said it, Thanks!

It is important that the child repeats all aspects of the request, thereby accepting full responsibility. If the child continues to play the video game, non-exclusion time-out is implemented (removal of video game), until completion of the request. The timeframe for completing the request is up to the parent. If for instance the agreement was that the trash be taken out before the child goes to bed, then the parent is instructed to not mention this chore for the rest of the evening – they no longer own this problem, ownership has been transferred to the child. After the child has gone to bed, if the chore has not been completed the parent calmly and gently awakens the child. Using limited words parent reminds the child of his chore for example: “Jack, the trash.”
Appendix G (Continued)

**SCENARIO 2:** Your child (applies to toddler through preschool) always begs you to let them walk instead of riding in the cart at the grocery store. However, every time you give in they take off running up and down the aisles, touching everything!

PARENT: (Prior to letting them out of the car) Billy, today you may walk beside Mommy’s cart. I will not allow running. (Upon selecting a cart, prior to entering the store) Billy, no running. You may walk beside Mommy or sit in the cart, you decide.

CHILD: I want to walk with Mommy.

Parent is to immediately begin engaging the child in shopping for example: “I’m looking for apples. Tell me when you see them.” Once the child spots the apples, parent is to immediately praise them and repeat the process. If the child does not comply and begins to run down the aisle, parent is to immediately grab the child and say...

PARENT: “You have decided to sit in the cart.” (while sitting them in the cart)

CHILD: (Crying, screaming, kicking…) No, Mommy! I’ll walk, no cart!

PARENT: I need you to calm down before we try walking again.

Non-exclusion time-out begins (contingent observation), where the parent withholds eye contact and verbal interaction (ignoring) until the inappropriate behavior subsides for 5-30 seconds. If tantrum continues excessively, parent is instructed to explain time-out rules (when it begins, behavior expected during, when it will end). Once inappropriate behavior subsides for 5-30 seconds, the steps are repeated allowing the child to make amends having experienced both positive and negative consequences.
Appendix G (Continued)

**SCENARIO 3:** Your child (applies to preschool through school-age) refuses to go to bed just about every night. She argues and argues until you’ve had enough! She then acts like she’s going to bed, but continues to “do things.” She uses the bathroom. She needs something to drink. She puts something in her backpack. By now she needs to use the bathroom again! After your face turns red, your head spins round and round, and lightening shoots from your fingertips, she goes to bed – and so do you from sheer exhaustion at this point!

PARENT: Tasha, (awaiting eye contact) I need you to stay in your room and the house quiet by 8 pm. You may either go to sleep at this time, or stay up reading quietly in your room. Now please repeat to me what I need done?

CHILD: But Mom I want to watch Raven tonight. Pleeease! She’s supposed to meet an alien. I can’t miss this one, I’ll look stupid at school tomorrow. Come on! (Parent does not engage in verbal interaction [ignoring], merely waits for appropriate response OR if an option, you may agree to record it for her to watch in the morning before school.) Why do you make me go to bed so early? Nobody at school goes to bed before 9 pm! Just let me stay up tonight, and tomorrow I won’t complain, pleeease! (Parent does not engage in verbal interaction [ignoring], merely waits a limited time for appropriate response.)

PARENT: Tasha, I need you to stay in your room and the house quiet by 8 pm. You may either go to sleep at this time, or stay up reading quietly in your room. Now what do I need?

CHILD: Do I have to read? Can I draw or do my activity pad?

PARENT: Tasha, I need you to stay in your room and the house quiet by 8 pm. You may either go to sleep at this time, or stay up reading quietly in your room. Now what do I need?

CHILD: You need me to be quiet in my room.

PARENT: I need the house quiet by what time?

CHILD: 8 pm.

PARENT: You said it, thanks.

If the child complies, parent is to pass by the room shortly after appointed time and praise the child. If the child does not comply and comes out of her room, immediately implement a mildly restrictive consequence. In this case, first a warning explaining what behavior is unacceptable. For example, “You may do something quietly in your room or
you will have to go to sleep, you decide.” If child does not comply then turn off the light and have child lay in bed. If the child continues to call out, parent is instructed to ensure all needs of the child have been met (had a drink, used the restroom, cold/hot addressed, etc.), and then ignore verbal interaction. If the child continues to come out of the bedroom, parent is to implement time-out. In this case, time-out would require securing the door closed for a specified period of time. If child begins to tantrum, once inappropriate behavior subsides for 5-30 seconds the door is opened and the steps are repeated allowing the child to make amends having experienced both positive and negative consequences.
Appendix G (Continued)

**SCENARIO 4**: Your children, or your child and another child (applies to preschool through adolescent) are playing together. Suddenly the yelling doesn’t sound so playful anymore, and the laughter turns into crying. You walk up to find your son playing with a toy, and the other child hysterical because your son refuses to stop playing with the toy and give the other child a chance to play with the toy!

PARENT: I see you both have a problem. Maria, (awaiting eye contact) you want to play with the toy; and Carlos, (awaiting eye contact) you want to play with the toy. I need you to come up with a solution to this problem that you both agree on.

Children will inevitably begin talking back to you at the same time, each telling their side of the story. Parent is to disengage eye contact, take possession of the toy, and signal children to stop talking (index finger to lips, hand stop sign, etc.). When children are silent, parent re-establishes eye contact and restates…

PARENT: I need you to come up with a solution to this problem that you both agree on.

If children continue to argue and cry, parent is to disengage eye contact and signal children to stop talking again. When children are silent, parent re-establishes eye contact and restates…

PARENT: I need you to come up with a solution to this problem that you both agree on.

Children will either begin negotiating or continue arguing and crying. If negotiations begin, once they’ve agreed to a plan parent is to give attention and praise to both children for cooperating, sharing, problem solving, etc. If arguing and crying persist, parent is to restate request this time adding a consequence…

PARENT: I need you to come up with a solution to this problem that you both agree on. The toy will stay in the garage until you come up with that plan.
Appendix G (Continued)

**SCENARIO 5**: Your child (applies to toddler through preschool) always seems to make a beeline for the things she shouldn’t touch! Whether the child speaks yet or not, the parent is instructed to redirect the child by both removing the child (or the object) and stating…

PARENT: Erin, granny’s glass kitty cat can break, but your stuffed kitty cat does not break. Please play with one of your toys.

If the child complies and begins playing with one of her toys, parent is to give attention and praise to the child. If the child reaches for the object again, parent is to calmly repeat the steps above. If the child begins to tantrum and the object has been removed, parent is to walk away from the child and ignore behavior. If the object is in place, parent is to physically remove the child while ignoring inappropriate behavior with as little attention as possible. If the child continues to tantrum and return to the object, parent gives warning regarding time-out.

PARENT: Erin, you may either play with your toys or take a time-out to calm down, you decide.

If child calms down and begins to play with toys, parent is to give attention and praise to the child. If the child’s tantrum persists, parent implements time-out procedures.

PARENT: I see you’ve decided to take a time-out (while taking to time-out area). When you have calmed down you may play with your toys.

If tantrum continues excessively, parent is instructed to explain time-out rules (when it begins, behavior expected during, when it will end). Once inappropriate behavior subsides for 5-30 seconds, the steps are repeated allowing the child to make amends having experienced both positive and negative consequences. If after time-out child continues to touch object, time-out procedures are repeated.
Appendix G (Continued)

**SCENARIO 6:** Your child (applies to school-age through adolescent) does not have enough hours in a day to reach level 200 on his latest and greatest video game. Although you’ve bought him the memory stick, it’s still a daily struggle to get him to stop playing for dinnertime, bath time, bedtime, etc!

PARENT: Cedric, (awaiting eye contact) Please pause the game and give me your attention, I need to speak with you.

CEDRIC: Sure Mom, just a minute.

PARENT: Cedric, (awaiting eye contact) Please pause the game and give my your attention, or I will take it away from you.

If child stops playing as requested, parent is instructed to reinforce their compliance before beginning the discussion. If child continues to play the video game, parent is instructed to stop the game however they choose (pause button, closing the top, taking possession of it, etc.), and let the child know they may resume when the parent is done speaking with them.

PARENT: Cedric, I would appreciate eating dinner together as a family around the table. When I call you for dinner, I need you to stop playing the video game and come to the dinner table. Now what do I need?

CEDRIC: But Mom I’m not hungry. I ate when I got home from school.

PARENT: That’s okay, you don’t have to eat but I still need you to stop playing the video game and come sit at the dinner table when I call you.

CEDRIC: But if I’m not going to eat, why can’t I sit there playing my game? Come one Mom, I bet Mike that I could get to level 200 before him. What’s the big deal? We never eat all together. (Parent does not engage in verbal interaction [ignoring], merely waits a limited time for appropriate response.)

PARENT: When I call you for dinner, I need you to stop playing the video game and come to the dinner table. Now what do I need?

CEDRIC: You need me to come sit at the table when you call me.

PARENT: I need you to come to the dinner table and what?

CEDRIC: Stop playing my video game.

PARENT: You said it, Thanks!
Appendix G (Continued)

If child does not show up when called for dinner, parent is to go to child and if child is playing a video game – shut it off. If child is talking on the telephone, parent is to walk up to child and with limited words say “Dinner,” and if available point to a watch, clock, etc. If a child argues or refuses to stop activity and come to dinner, then time-out may be implemented. In such cases, nonexclusion time-out would be appropriate for instance removing the video game or telephone from the child and losing that privilege until a specified time (after dinner, rest of the day, or tomorrow). After specified time without the privilege, child is given a second chance to make amends having experienced both positive and negative consequences.
Appendix H

Evaluation Form

1. Do you feel the extra role-play sessions helped you learn the parenting skills discussed in class?  Check one: □ Yes □ No

2. Which parenting skills from the role-play sessions have you tried using?
   □ Clear Communication   □ Positive Attention   □ Ignoring   □ Time-Out

3. Please check each parenting skill you found to be most useful?
   □ Clear Communication   □ Positive Attention   □ Ignoring   □ Time-Out

4. Please check each parenting skill you found to be least useful?
   □ Clear Communication   □ Positive Attention   □ Ignoring   □ Time-Out

5. Circle your comfort level with using the following parenting skills.

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<th>Extremely Comfortable</th>
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<td>Positive Attention: 1 2 3 4 5 6 7</td>
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<td>Time-Out: 1 2 3 4 5 6 7</td>
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6. Circle the likelihood that you will continue to use this skill in the future.

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<td>Time-Out: 1 2 3 4 5 6 7</td>
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7. Would you recommend these extra sessions of role-playing scenarios be included in future “Winning at Parenting” classes?  Check one: □ Yes □ No
   Comments: ________________________________________________________________
Appendix H (Continued)

8. Circle the number that best represents your feelings regarding the role-play instructor.

1 2 3 4 5 6 7
Least Helpful Extremely Helpful

9. Any Other Comments: ____________________________________________________________

________________________________________________________________________________
Appendix I

“MyTell” Cards

- Listen with full attention.
- Listen silently.
- Listen with a sound
  - Um, Oh, yes, I see.
- Give the feelings a name.
  - Sad, angry, frustrated

Listening
Appendix I (Continued)

Games for Listening

1.) I Spy: One person selects a visible object in the room that has a certain color and says: "I spy something ______" (puts in the color of the object) Other players try to guess the object by asking yes or no questions. The first one to guess the object is "It" and gets to pick the next object.

*You can also play this game using shapes, the first letter in the name of an object, or by finding an object that is shaped like a letter of the alphabet.

2.) What am I - one person (the hint giver) picks a person, place or thing and says, "I am a _____." (Person if it is a person, place if it is a place or thing if it is a thing.) The other players get one guess each. Then the hint giver gives another clue (like the color, size, what it does, etc...) the other players get one guess each. This hint giving goes on for 5 more hints. If no one guesses, then the hint giver tells the answer and the person to the left is next.

3.) Name that tune: One person hums a familiar song and the other players try to guess. The person who guesses is the next hummer. If there is a tie, the tied players can say how many hums it will take to guess the next song. (The same hummer picks the tie breaking tune.)

Skill Builder
Appendix I (Continued)

1. Be Specific tell child
   What 👀👀
   Who 😐��?
   Where 🌍
   When ⏰

2. Don't use YOU

3. I messages:
   I feel...
   When I...
   Because I...

Communicating
Appendix I (Continued)

Make a request using eye contact

No

Ignore the cons
Restate the request
What do I need?

↓

Child restates request

↓

You got it,
Thanks!

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Appendix I (Continued)

Alternatives to NO!

Give information
(leave out \( \text{NO} \) )

Accept feelings

Describe the problem.

Substitute a YES for a no.

Give yourself time to think.

Communicating
Appendix I (Continued)

- Say no only when needed and stick to it.
- Don't lie.
- Don't say because I said so!

No means no!
Games for Communicating

**Staring Contest (practice eye contact)**
Sit or stand face to face. One person stares at the other until one of you blinks. You can keep track by counting out loud. Try to increase your concentration each time you play. If there is more than one player, the winner takes on the next player until there is only one winner.

**Who am I? (practice I-messages)**
One person starts saying: I am a ____ (person, place or thing). Other players guess without any clues. Then a clue is given starting with another "I-message". I ____ (live, eat, breathe...) Each player takes a turn guessing. Then another "I-message" clue is given. Continue until someone guesses or 10 clues are given.

**Charades (practice you feel messages)**
One person, without using any words or sounds, acts out a person, place or thing that is expressing a feeling. For example a fisherman sad because he didn’t catch any fish. Game ends when someone guesses or all players get 3 guesses.

Skill Builder
Appendix I (Continued)

Make a request...

Yes

Give praise, attention, or affection

No

Explain Time-Out Rules

Start Time-Out

Ignore cons behavior stops for 30 sec.

STOP Time-Out
Appendix I (Continued)

Time-Out Ideas

Exclusion
- Remove child from area
- Place in a less desirable area

Non-exclusion
- Ignoring
  (no talking, touching or looking)
- Stop enjoyment
  (sit in corner, turn off TV/radio)