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## Do Reinforcer Surveys Enhance a Brief Parenting Skills Program for Attention-Deficit/Hyperactivity Disordered Children?

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**DO REINFORCER SURVEYS ENHANCE A BRIEF PARENTING SKILLS  
PROGRAM FOR ATTENTION-DEFICIT/HYPERACTIVITY  
DISORDERED CHILDREN?**

by

**Maria A. Channell**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Philosophy  
Department of Psychology**

**Western Michigan University  
Kalamazoo, Michigan  
June 1997**

# **DO REINFORCER SURVEYS ENHANCE A BRIEF PARENTING SKILLS PROGRAM FOR ATTENTION DEFICIT/HYPERACTIVITY DISORDERED CHILDREN?**

**Maria A. Channell, Ph.D.**

**Western Michigan University, 1997**

Several clinical researchers have documented the benefits of evaluating reinforcer preference prior to the implementation of behavioral parent training programs. However, this has not been specifically tested with Attention-Deficit/Hyperactivity Disordered (ADHD) population in relation to parent training. This between groups study investigated whether systematically altering parent delivered reinforcers to match children's preferred reinforcers would result in an even greater increased compliance and decreased noncompliance.

One group received a brief (4-6 session) parenting program based on Patterson's (1974) model. A second group received the same program with an added component wherein the child completed a reinforcer survey prior to the beginning of treatment. Subjects included 14 families with medicated ADHD children ages 6-12 who were randomly assigned to groups. Parents in the group that systematically incorporated the children's reinforcer preferences into their program reported significantly fewer noncompliances on a weekly report form than those parents in the traditional treatment control group. During the one hour independent home

observations of families, there were significantly higher levels of noncompliance observed in the reinforcer preference group than in the traditional treatment control group.

Results of the study are discussed in terms of the implications for the use of reinforcer surveys as an additional component of parent training in ADHD children.

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## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
LIST OF TABLES .....	viii
LIST OF FIGURES .....	ix
INTRODUCTION .....	1
Importance of Parenting Strategies for an Attention-Deficit/ Hyperactivity Disordered Population .....	1
Support for the Effectiveness of Parent Training .....	3
Factors That Influence the Outcome of Parent Training .....	4
Parent Factors .....	4
Reinforcer Preference .....	6
METHOD .....	12
Participants .....	12
Measures .....	13
Child Measures .....	13
Children's Reinforcer Survey Schedule .....	13
Child Verbal Report: Child's Reinforcer Preference .....	14
Concurrent Measure .....	15
Compliance and Non-compliance .....	15
Children's Depression Inventory .....	15

## Table of Contents - Continued

Parent Measures .....	16
Verbal Report by Parents:	
Child's Reinforcer Preference .....	16
Compliance and Non-compliance .....	16
Concurrent Measures .....	17
The Child Behavior Checklist .....	17
Beck Depression Inventory .....	18
State-Trait Anxiety Inventory .....	18
Dyadic Adjustment Scale .....	19
Parenting Stress Index .....	19
Knowledge Checks .....	20
Parent Satisfaction With Treatment .....	20
Experimental Design .....	20
Procedure .....	21
Parent Training Program .....	21
Tracking .....	22
Positive Point Program .....	22
Time-Out .....	23
Steps Taken to Ensure Uniform Delivery of the Independent Variable .....	23
Home Observations .....	24

## Table of Contents - Continued

Human Participants Protection .....	26
<b>RESULTS .....</b>	<b>27</b>
Completers Versus Non-completers .....	27
Descriptive Measures for Completers Versus Non-completers .....	27
Compliance and Non-compliance Levels for Completers Versus Non-completers .....	30
Knowledge Check and Skills Check .....	31
Steps Taken to Ensure Uniform Delivery of the Independent Variable .....	33
Reinforcer Preference for the Experimental Group .....	33
Descriptive Measures for the Experimental Group Versus Control Group at Pre-Test .....	34
Maternal Report of Compliance and Non-compliance Levels for the Experimental Versus Control Group .....	35
Home Observations of Compliance and Non-compliance Levels for the Experimental Versus Control Group .....	36
Nonparametric Analyses .....	37
Descriptive Measures for the Experimental Group and Control Group .....	37
Compliance and Non-compliance Levels .....	40
Knowledge Check .....	43
Skill Check .....	43
Parent Evaluation of Treatment .....	45

## Table of Contents - Continued

DISCUSSION .....	46
Non-completer Rate .....	46
Accuracy of Treatment Delivery .....	49
Broad Treatment Effects .....	51
Evaluation of the Primary Hypothesis .....	52
Implications of Findings .....	54
Strengths Related to Internal Validity .....	54
Clinical Implications .....	55
Limitations .....	56
Future Directions .....	57
Conclusions .....	58
APPENDICES	
A. Subject Recruitment Flyer .....	59
B. Child's Reinforcer Preference Survey .....	61
C. Point Incentive Charts .....	67
D. Knowledge Checks .....	71
E. Parent Evaluation of Treatment .....	78
F. Parent Consent Form - Control Group .....	81
G. Parent Consent Form - Experimental Group .....	83
H. Child Assent Form .....	86

## Table of Contents - Continued

### APPENDICES

I. Medication Status Sheet .....	88
J. Parenting Strategies Manual .....	90
K. Behavior Checklists for Therapist Adherence .....	111
L. Skills Check Form .....	121
M. Procedures to Train Home Observers .....	123
N. Human Subjects Institutional Review Board Approval .....	128
BIBLIOGRAPHY .....	130

## LIST OF TABLES

1. Comparisons Between Completers and Non-completers for Child and Parent Variables .....	29
2. Comparisons for Completers Versus Non-completers for Maternal Reports and Home Observations of Child Compliance and Non-compliance (Frequencies Reported) .....	31
3. Comparisons for Completers Versus Non-completers for Maternal Reports and Home Observations of Child Compliance and Non-compliance (Proportions Reported) .....	32
4. Group Differences Between the Experimental Group and the Traditional Treatment Control Group at Pre-Test .....	35
5. Home Observation Frequencies of Child Compliance and Non-compliance .....	41
6. Home Observations Proportions of Child Compliance and Non-compliance .....	42
7. Percentage of Correct Parent Responses on the Knowledge Checks .....	44

## LIST OF FIGURES

1. Weekly Parent Report of Child Compliance for Experimental and Control Groups (Frequency) . . . . .	37
2. Weekly Parent Report of Child Non-Compliance for Experimental and Control Groups (Frequency) . . . . .	38
3. Weekly Parent Report of Child Compliance for Experimental and Control Groups (Proportions) . . . . .	39
4. Weekly Parent Report of Child Non-Compliance for Experimental and Control Groups (Proportions) . . . . .	40



## INTRODUCTION

### Importance of Parenting Strategies for an Attention-Deficit/Hyperactivity Disordered Population

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common diagnosis in children. The American Psychiatric Association estimates the prevalence rate of ADHD is approximately 1-7% of children (APA, 1994). ADHD is characterized by symptoms of inattention and impulsivity. Hyperactivity often occurs in conjunction with inattention and impulsivity, but a diagnosis of ADHD can be made in its absence (APA, 1994).

Currently, there is controversy regarding the most effective treatment for ADHD. Stimulant medications such as methylphenidate, dextroamphetamine and magnesium pemoline have been documented as effective in 60-90% of ADHD children in reducing hallmark symptoms (Hinshaw, 1994). These findings illustrate why stimulant medication is frequently prescribed for children who exhibit ADHD type behaviors.

However, even though stimulant medication is generally considered the preferred treatment for ADHD, there is concern that some children may be prescribed medication too easily, perhaps due to an over-diagnosis of ADHD. Furthermore, it has been suggested that for many children placed on stimulant medication, no systematic evaluation of the medication's effects is carried out (Gadow, 1992; Pelham, Carlson, Sams, Vallano, Dixon, & Hoza, 1993; Schleser, Armstrong & Allen, 1990).

Finally, many researchers have suggested that treatment gains associated with

Finally, many researchers have suggested that treatment gains associated with stimulant medication are often restricted to reducing behavioral excesses (e.g., hyperactivity) and not necessarily directed towards increasing behavioral deficits such as social, cognitive or academic skills, prosocial behaviors such as compliance with adult requests, or higher task completion rates (Schleser et al., 1990; Whalen, Henker, Swanson, Granger, Kliewer, Spencer, 1987). Medication alone cannot produce long-term treatment gains without adjunctive or alternative forms of psychological intervention (Barkley, 1990; Hinshaw, 1994).

Furthermore, the physiological, social and attributional consequences of stimulant medication have been documented in ADHD children and this risk appears to increase with greater doses (Barkley, 1977; Barkley, McMurray, Edelbrock & Robbins, 1990; Roche, Lipman, Overall & Hung, 1979; Whalen & Henker, 1976). Deleterious physiological consequences have included disruptions in height and weight gains, appetite loss, nausea, headaches, stomachaches, lethargy, and insomnia (Barkley, 1977; Barkley et al., 1990; Horn, Ialongo, Pascoe, Greenberg, Packard, Lopez, Wagner & Puttler, 1991; Roche et al., 1979). Negative social consequences documented have included increased teasing by peers (Whalen & Henker, 1976). Finally, additional research suggests that medication may exert a negative impact on the attributions of children with learning and behavior problems (Allen & Drabman, 1991; Whalen & Henker, 1991a). It has been argued that medicated children attribute their behavior to external factors (i.e., the drug) and perceive their efforts as relatively insignificant with respect to improvements in performance and behavior change (Allen & Drabman, 1991; Whalen & Henker, 1991a).

The limitations of stimulant medication suggest the necessity of identifying adjunctive or alternative behavioral interventions. Several researchers have suggested that if clinicians can help parents to increase their child's compliance with adult requests then children will be better able to complete tasks independently, exhibit more on-task behaviors, demonstrate more persistence on difficult tasks and experience fewer long-term problems with antisocial or aggressive behaviors (Forehand & McMahon, 1981; Patterson, 1986).

### Support for the Effectiveness of Parent Training

Effective interventions for parents whose children exhibit behavioral disturbances have been developed in recent years (Forehand & McMahon, 1981; McMahon & Wells, 1989; Patterson, 1986; Webster-Stratton, 1984). Currently, existing parent training programs are typically brief (4-8 weeks) and teach parents to help their children decrease inappropriate behaviors and increase desired behaviors. Such treatment gains have demonstrated generalization from the clinic to the home setting (Webster-Stratton, 1984) and have been successful with clients from all socioeconomic levels, although effectiveness drops off somewhat with less educated parents (Webster-Stratton & Hammond, 1988). Numerous studies suggest that parent training programs have been successful in producing improvements in conduct problem children both immediately post-treatment (Forehand & Atkeson, 1977; Herbert & Iwaniec, 1981; Pied, Roberts & Forehand, 1977) and have maintained these treatment gains at follow-up (Forehand, Sturgis, McMahon, Aguar, Green, Wells & Breiner, 1979; Patterson, 1974;

Patterson & Fleischman, 1979). For example, Patterson conducted a study of 27 socially aggressive boys and reported that there was approximately 60% reduction in deviant behaviors upon completion of therapy for 75% of cases.

Furthermore, two thirds of the families reported a significant drop in behavior problems for which they were originally referred. Follow-up data suggested that these treatment gains were maintained over a one year period during which "booster shot" therapy sessions were administered as needed.

### Factors That Influence the Outcome of Parent Training

Researchers have investigated variables which are believed to influence whether parent training programs will be successful or not (Dumas, 1986; Griest, Forehand & Wells, 1981; Griest & Wells, 1983; Patterson, 1986; Reid & Patterson, 1976; Wahler & Dumas, 1984; Wahler & Graves, 1983).

#### Parent Factors

A number of studies suggest that the family's ability to benefit from parent training may be influenced by cognitive, psychological, interpersonal and extra familial factors (Dumas & Wahler, 1983; Griest & Wells, 1983; Reisinger, Frangia & Hoffman, 1976; Webster-Stratton, 1985a). Parents' psychological and cognitive factors have been identified as having a potential impact on both treatment gains and maintenance following the implementation of parent training programs. Researchers have observed that pre-treatment levels of maternal depression and anxiety were significantly related to treatment

failure, loss of treatment gains during follow-up evaluations, and dropout during treatment and follow-up (Forehand, Furey & McMahon, 1984; McMahon, Forehand, Griest & Wells, 1981). Additional research (Wahler & Afton, 1980) has suggested that parents who continued to have negative perceptions of their children's behavior post-treatment failed to maintain positive behavioral treatment effects.

Single parent families have been found more likely to drop out of parent training than intact families, and intact families were more successful in maintaining treatment effects over time than single parent families (Strain, Young & Horowitz, 1981). Other studies have examined the relationship between marital status, marital discord, and treatment outcome. Reisinger et al. (1976) and Webster-Stratton (1985a) found a relationship between treatment failure and marital problems. However, contradictory evidence suggests that the degree of marital satisfaction has no impact on treatment outcome (Oltmanns, Broderick & O'Leary, 1977).

Some studies suggest that families who are socioeconomically disadvantaged do not perform well in parent training programs and are more likely to drop out (McMahon et al., 1981; Reid & Patterson, 1976; Wahler, 1980; Wahler & Afton, 1980; Webster-Stratton, 1985a). According to these authors, socioeconomically disadvantaged was defined according to low income, low education, single parent family, poor area of residence, large number of children in family and referral by an outside agency. Further, Dumas and Wahler (1983) proposed that socioeconomic disadvantage in conjunction with social isolation resulted in an increase in the likelihood of treatment failure. In addition to socioeconomic status, the degree of life crisis and environmental stresses (e.g., moving

to a new neighborhood, death in the family, unemployment) may also significantly affect a family's ability to maintain treatment effects (Webster-Stratton, 1985a).

Most investigators have concentrated on the influence of interpersonal variables rather than examining procedural changes within the parent training program itself which could be manipulated to improve the effectiveness of the program. Thus, a pre-intervention assessment of specific program variables which may contribute to subsequent treatment gains after the completion of the parent training program were examined in this study.

### Reinforcer Preference

Reinforcement is a necessary component for establishing and/or maintaining operant behaviors (e.g., increased compliance, increased positive social interactions; Pace, Ivancic, Edwards, Iwata & Page, 1985). Positive reinforcers have frequently been used to increase desirable behaviors and decrease undesirable behaviors (Vatterott, Callier & Hile, 1992). Consequently, many researchers have stressed the importance of selecting suitable reinforcers when developing and implementing behavioral interventions (Atkinson, Jenson, Rovner, Cameron, Van Wagenen & Petersen, 1984; Cautela & Brion-Meisels, 1979; Fox, Rotatori, Macklin & Green, 1983; Hogden, 1985; Houlihan, Rodriguez, Levine & Kloeckl, 1990; Pace et al., 1985). Specifically, reinforcer preference has been assessed prior to or in conjunction with both assessments and interventions (i.e., desensitization programs, assessment of depression, treatment of enuresis, and behavior management of junior high school students; Cautela, 1970; Cautela & Wisocki, 1971;

Wolpe, 1973). This strategy has been applied widely to include pediatric, adult and geriatric populations and with both non-clinical and clinical populations; clinical populations include autistic children, inpatient psychiatric children, children with special needs, and developmentally disabled individuals (Atkinson et al., 1984; Dewhurst & Cautela, 1980; Houlihan et al., 1990; Jones, Mandler-Provin, Latkowski & McMahon, 1988; Steege, Wacker, Berg, Cigrand & Cooper, 1989).

Despite the documented importance of this practice, it has been suggested that conducting pre-intervention assessments of reinforcer preference is often dismissed (Pace et al., 1985). Therefore, it has been hypothesized that failure to promote behavior change in some individuals could be the result of poor stimulus selection rather than the mismanagement of contingencies (Repp, Barton & Brulle, 1983). Parent training programs have been documented as failing to promote behavior change in approximately 25% of cases (Patterson, 1974). Perhaps, this failure could be at least partially accounted for by poor stimulus selection rather than difficulties with contingency management when implementing the program.

The only way to determine whether or not a stimulus is functioning as a reinforcer is to assess whether there is an increase in the future frequency of the behavior following the presentation of that stimulus. Thus, ideally when selecting which reinforcers to use in treatment, each potential reinforcer should be assessed for its impact on behavior (Vatterott et al., 1992). Unfortunately, the time required to systematically assess each potential reinforcer places limitations on the utility of this practice (Vatterott et al., 1992).

One strategy implemented for assessing reinforcer preference in individuals is

exposing the person to an array of stimuli and recording the duration or frequency of interaction with each stimulus (Barrett, 1962; Fischer, Piazza, Bowman, Hagopian, Owens & Slevin, 1992; Pace et al., 1985; Quilitch, Christopherson & Risley, 1977). However, it has been suggested that this strategy is practical to use only when simpler or more economical methods of reinforcer selection (i.e., verbal report or reinforcer surveys) are not effective (Favell & Cannon, 1976). For example, this procedure is typically only used with individuals who have a limited verbal repertoire and may be unnecessarily time consuming for most individuals (Barrett, 1962; Pace et al., 1985; Quilitch et al., 1977).

A more efficient strategy of evaluating reinforcer preference simply involves asking the individual what they prefer (Barrett, 1962). This can be done by asking the individual to complete a reinforcer preference survey or by a verbal report. Concurrent validity for reinforcer preference has been demonstrated between individuals and those who are judged to know them well (i.e., parents, teachers, staff members; Atkinson et al., 1984; Houlihan et al., 1990). It has also been suggested that a consensus be reached between parents, teachers, staff people, and others who know the individual well when relying on their subjective reports (Luiselli, 1995). Traditional versions of the parent training program utilize parents' guesses without child input. If the parent is an ineffective guesser, additional treatment sessions may be required to identify more desirable reinforcers. Thus, this manipulation should decrease the probability of requiring additional sessions and may increase the effectiveness of the parent training program.

Reinforcement checklists, either traditional paper and pencil measures or computerized alternatives have been cited as a facile way to identify effective reinforcers



prior to the implementation of behavioral programs (Cautela, 1968; Cautela & Brion-Meisels, 1979; Cautela & Kastenbaum, 1967; Cautela & Lynch, 1983; Cautela & Wisocki, 1971; Dewhurst & Cautela, 1980; Vatterott et al., 1992). In addition to their ease of administration, useful information can be easily accrued in a short time (Atkinson et al., 1984; Houlihan et al., 1990; Phillips, Fischer, & Singh, 1977). Reinforcer surveys can also function to generate ideas for new reinforcers for a child who seems to be satiated on frequently used reinforcers (Atkinson et al., 1984). Additionally, it has been suggested that the administration of this instrument helps to build rapport between individuals prior to the implementation of the behavior program (Houlihan et al., 1990).

However, perhaps the most important contribution of evaluating reinforcer preference is the potential for improving the effectiveness of many behavioral interventions. In fact, some have suggested that identifying reinforcing stimuli is critical to the success of training programs (Green, Reid, Canipe & Gardner, 1991). For example, Pace et al. (1985) conducted an experiment where they identified potential reinforcers in six profoundly mentally retarded individuals using a two step process. First, participants were repeatedly exposed to sixteen stimuli and approach behaviors to each of the stimuli were used to identify preferred and non-preferred stimuli. Subsequently, the reinforcing properties of preferred and non-preferred stimuli were examined by delivering them contingently on the occurrence of arbitrarily selected responses. Preferred stimuli typically produced higher response rates than did baseline or non-preferred stimuli.

Green et al. (1991) conducted a series of studies to examine the impact of

reinforcer preference on the outcome of a training program. Participants included eighteen individuals with profound multiple handicaps. Each stimulus was presented thirty-six times and approach behaviors were recorded to determine preference for a particular stimulus. Once this was determined, participants were trained to learn a new skill (e.g., activating a switch). Results suggested that highly preferred stimuli were likely to function as reinforcers and non-preferred stimuli did not function as reinforcers.

A second factor that must be considered when implementing behavior programs is that the participants have adequate variation of the preferred stimuli or activities. For example, in this study, when the child has achieved a reinforcement opportunity, he/she will be allowed to choose from his previously generated list of most preferred stimuli and activities. This selection process is necessary because if a stimulus or activity is used as a reward repeatedly, it is possible that it will lose its reinforcing effectiveness (Luiselli, 1995). Thus, if a parent were to repeatedly choose a stimulus or activity that was initially preferred by the child, it is possible that with repeated administrations, it would be as ineffective as an item or activity that was not preferred by the child initially.

The studies cited suggest that assessing reinforcer preference and implementing preferred reinforcers in a behavior management program may result in treatment gains following the completion of the program. However, these procedures have not been empirically evaluated with ADHD populations. Consequently, conducting a systematic evaluation of general reinforcer preference may function to increase the effectiveness of the positive point and time-out components of the parent training program resulting in an overall increase in compliance for ADHD children.

The purpose of this between groups study was to investigate whether systematically altering parent delivered reinforcers to match their children's preferred reinforcers would result in even greater increased compliance and decreased non-compliance. One group received a brief (4-6 session) parenting program based on Patterson's (1974) model. A second group received the same program with an added component wherein the child completed a reinforcer survey prior to the beginning of treatment. It was hypothesized that the children in the group receiving the treatment plan modification would demonstrate even greater increased compliance and decreased non-compliance when compared to the traditional treatment control group.

## METHOD

### Participants

Participants completing the program included 14 Attention-Deficit/Hyperactivity Disordered children in grades two to six (ages 6.0 to 11.67) and their parent(s). The sample included 5 girls and 9 boys. The children's mothers participated in all cases. The children's fathers participated in four cases.

Participants were recruited through schools, clinics and through distribution of brochures (see Appendix A) in a Southwest Michigan community. The obtained sample represents approximately 20% of the participants who completed the telephone screening interview. Approximately 65% of the potential participants did not meet eligibility criteria or were not interested in participating when provided with additional information about the study during the screening interview. Eleven families, approximately 15% of those who completed the telephone screening interview and agreed to participate, dropped out prior to completing the study. Non-completers reported the program was difficult to complete because of the following: (a) the time commitment involved (attending sessions, between sessions homework and home observations); (b) lack of support from family members who did not participate in the program; and (c) values which conflicted with program structure and rationale.

Following a referral to the parent training program at the Western Michigan

University Psychology Clinic, potential participants participated in a brief telephone interview conducted by either the project director or the author. This provided detailed information about the program and what would be required of any family that chose to participate. Participants were excluded if they had a dual diagnosis other than Conduct Disorder, Oppositional Defiant Disorder or a Disruptive Behavior Disorder Not Otherwise Specified. Participants were also excluded if parents reported they were not currently prescribed stimulant medication (i.e., Ritalin, Cylert). There were no reported changes in the participants' medication status during the course of the study.

## Measures

### Child Measures

#### Children's Reinforcer Survey Schedule

The Children's Reinforcement Survey Schedule (Cautela & Brion-Meisels, 1979; see Appendix B) was developed to identify stimuli which maintain children's behavior. There are several forms of the scale. Forms A and B each consist of 25 items. The same categories (food, beverages, toys, games, art, crafts, music, reading, sports, extracurricular school activities and privileges, academic participants, television, holidays, going out, animals, other people, recognition and protection) were used in both forms though different items were used in each of the individual forms. Therefore, either version can be administered to children in kindergarten through grade three. When completing the survey, the child is asked to indicate how much he/she likes a particular

material, object, animal, person or activity. The child must rank his/her preference on a three point Likert scale (dislike, like, like very much). The ranked items are scored from 0 (dislike) to 2 (like very much).

Form C contains 80 items can be used to assess stimulus preference in children in grades 4 through 6. The first 75 items rank preference on the three point scale. Form C uses all the same categories as forms A and B in addition to clothes, mechanics, groups, money and correctness. Preference for a material, object, animal person or activity is ranked as described above. Unlike Forms A and B, Form C has five open ended questions relating to other possible reinforcers.

Adequate test-retest reliability for forms A, B and C over a three week period was reported  $r = .48$ ,  $r = .48$  and  $r = .72$  respectively. Adequate concurrent validity has also been reported (Cautela & Brion-Meisels, 1979).

#### Child Verbal Report: Child's Reinforcer Preference

A brief interview with the child was conducted following completion of the reinforcer survey to elaborate on reinforcer preference. This functioned to identify stimuli that were reinforcing to the individual, but were not identified with the reinforcer survey. The child was asked by the therapist if there was any particular thing or activity that he/she really liked or enjoyed that was not addressed in the survey. He/she was asked to rank these identified item(s) as like or like very much.

### Concurrent Measure

The concurrent measure was the type of reward selected by the child during the Positive Point Program (see Appendix C) for the Point Incentive Charts parent(s) completed weekly following completion of the Positive Point Program session. The chart was used to monitor rewards actually offered by the parents and selected by the child.

### Compliance and Non-compliance

Compliance and non-compliance were broadly defined as the two possible responses of a child following a parental request. More specifically, compliant behavior was when the child began to do what he/she was told within 15 seconds, without any arguing, whining or back talk. Non-compliance was anything else. Parent observations were collected for an hour/day seven days a week from the Tracking session forward.

### Children's Depression Inventory

The Children's Depression Inventory (CDI) is a 27-item self-report questionnaire that assesses cognitive, behavioral and somatic symptomatology of depression in children (Kovacs, 1981, as cited in Finch, Saylor, Edwards & McIntosh, 1987). Each item consists of three statements from which the child is told to pick the one which best describes him/her in the past two weeks. Each item was developed to assess a specific symptom of depression.

The three choices range from none to mild to severe symptomatology. Test-retest reliability coefficients reported by Finch, Saylor, Edwards and McIntosh (1987) range

from .82 over two weeks to .66 and .67 over longer time intervals.

## Parent Measures

### Verbal Report by Parents: Child's Reinforcer Preference

An interview with the parent(s) was conducted to identify stimuli that parents believe would function as effective reinforcers for their children. This identified any additional stimuli that they believe to be reinforcing for their child beyond stimuli already identified with the reinforcer survey (Houlihan et al., 1990). Specifically, after asking the parent(s) to complete the Children's Reinforcement Survey Schedule according to how they think their child would answer it, the child's therapist asked parent(s) to identify any item or activity that they think their child really likes or enjoys that has not been addressed in the survey. Subsequently, they were asked to rank the identified items as like or like very much. Researchers suggest that there typically is agreement between child and parental responses (Atkinson et al., 1984; Houlihan et al., 1990). However, when discrepancies were found between child and parental responses in this study, the child's responses dictated which reinforcers were implemented during the parent training program.

### Compliance and Non-compliance

Parent observations for child compliance and non-compliance were collected for an hour/day seven days a week from the tracking session (session number two) through completion of the time-out session (typically session number four).



### Concurrent Measures

The concurrent measures were parent reports of: (a) the frequency of child compliance and non-compliances each week from the tracking session through to the completion of time-out; (b) the frequency of time-outs used in the week following the time-out session; and (c) the type of backup punisher chosen by parent(s) during the time-out procedure. See Appendix C for the Point Incentive Charts parent(s) completed weekly following completion of the time-out session. The chart was used to monitor child compliance and non-compliance, use of time-outs, and backup punishers used by the parents during the time-out component of the program. The chart was also used to identify which rewards were offered by the parents and then selected by the children.

### The Child Behavior Checklist

Parents also completed the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991) which is comprised of a Social Competence Scale and the Behavior Problem Scale which includes 20 and 118 items respectively. Responses to items generate three scores: Activities, Social Involvement and School Performance. The Behavior Problem Scale assesses various behavioral, social, emotional and physical issues. Test-retest reliability and inter-parent agreement are acceptable (Achenbach & Edelbrock, 1983). There is evidence that the CBCL discriminates children with attention and hyperactivity problems from children with other problems (Mash & Johnson, 1983a).

### Beck Depression Inventory

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961) is a 21-item multiple choice self-report instrument. Each item consists of several statements which address a specific symptom of depression. Each statement is scaled from 0-3. The participant indicates which of these ordered statements best represent his/her current state. Most items emphasize cognitive content. However, affect, overt behavior, somatic symptoms, and interpersonal symptoms are also addressed. A test-retest reliability of .75 was reported for 23 undergraduates after three months (Miller & Seligman, 1973, as cited in Lezak, 1995). Test-retest reliability ranging from .74 to .93 was reported for several subject groups (Kasznik & Allender, 1985, as cited in Lezak, 1995). The Beck Depression Inventory has demonstrated a strong concurrent validity correlating significantly with a number of other depression measures (Spren & Strauss, 1991, as cited in Lezak, 1995). Additionally, the Beck Depression Inventory has been found to correlate significantly with clinicians' ratings of depression and has been demonstrated to be sensitive to clinical changes. Beck (1972) reported that the instrument has adequate discriminative validity.

### State-Trait Anxiety Inventory

The State-Trait Anxiety Inventory (STAI; Spielberger, 1983) was designed to assess state anxiety which refers to a transitory emotional condition defined by subjective feelings of tension and apprehension and trait anxiety which refers to a relatively stable proneness to anxiety. State anxiety is measured by 20 short descriptive statements to

which the individual answers how he/she is feeling at that exact moment (e.g., I am jittery; I am calm). The answers are recorded according to the intensity of the feeling (not at all, somewhat, moderately so, very much so). When measuring trait anxiety, individuals are asked to indicate how they generally feel by marking the frequency with which each of the 20 statements (e.g., I am a steady person; I am inclined to take things hard.) applies to them (almost never, sometimes, often, almost always). Internal consistency reliability for both the state and trait anxiety forms is adequate (in the .80's and .90's). Adequate construct validity has been demonstrated (Anastasi, 1988).

#### Dyadic Adjustment Scale

The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a 32-item questionnaire which is designed to assess the quality of marriage of similar dyads. It can be used to measure a general satisfaction of an intimate relationship by using a total score which is a sum of all items. Scores can range from 0-151. Higher scores reflect a better relationship. The DAS is reported to have a good internal consistency with an alpha of .96. The DAS has demonstrated validity by discriminating between married and divorce couples. The authors reported that this instrument has also demonstrated concurrent validity, correlating with the Locke-Wallace Marital Adjustment Scale.

#### Parenting Stress Index

The Parenting Stress Index (PSI; Burke & Abidin, 1980) is a 150-item questionnaire that yields six scores relating to child behavioral characteristics (e.g., mood,

compliance, etc.), eight scores relating to maternal characteristics (e.g., depression, sense of competence as a parent, etc.), and two scores relating to situational and life stress events. These scores can be summed to yield the following domain scores: Child Domain, Parent Domain and Total Stress Domain. Test-retest reliability is adequate and has been reported to range from .70 to .90 for the domain scores over a three to four week period (Abidin, 1983).

### Knowledge Checks

Parents were asked to complete a knowledge check following each of the three sessions (tracking, positive point program and time-out). This assessed parents' understanding of the parenting skills taught. These assessments were developed by the author of the parent training program used in this study (see Appendix D). These were presented at the completion of each session and at a two month follow-up. Knowledge check procedures were obtained from McGrath's Masters thesis proposal (1995).

### Parent Satisfaction With Treatment

Parents were asked to complete a treatment satisfaction questionnaire following completion of the parent training program (see Appendix E). Parent satisfaction procedures were obtained from McGrath's Masters thesis proposal (1995).

## Experimental Design

Participants were randomly assigned to one of two groups (treatment or control).

Seven families were assigned to the treatment condition and an equal number of families were assigned to the control condition.

## Procedure

### Parent Training Program

During the initial session, consent and assent forms were collected for both adult and child participants (see Appendices, F, G and H). Parent(s) completed a diagnostic interview as well as the diagnostic and medication status sheet (see Appendix I) which both served as a final check to determine that eligibility was met for the study. Parents also completed the Child Behavior Checklist, the Beck Depression Inventory, the State-Trait Anxiety Inventory, the Dyadic Adjustment Scale and the Parenting Stress Index. Parents were also asked to complete all three knowledge checks prior to implementation of the program. Children were asked to complete the Children's Depression Inventory. Children in the experimental group also completed the Children's Reinforcer Survey Schedule and a verbal report of reinforcer preference. Parents in the experimental group completed the Children's Reinforcer Survey Schedule and a verbal report of reinforcer preference according to how they believed their child completed it. The Parent Training Program consisted of three phases (tracking, positive point program and time-out; see Appendix J) which were conducted over four to six sessions. Permission to reproduce the manual was received from Dr. Armstrong.

### Tracking

During the second session, the tracking phase was introduced and parents learned how to track their child's compliance and non-compliances in their home. Parents completed the first knowledge check at the end of this session. Parents tracked for 1 hour/day for the duration of the program. These data were summarized in the form of frequencies for each week of participation.

### Positive Point Program

Once the tracking phase was successfully completed, the positive point program was implemented. This program is designed to teach parents how to increase desirable behaviors (i.e., compliance with parental requests and independent completion of chores) by using a daily reward system. This commenced in the third session and continued for two weeks through the fourth session. Prior to commencing the positive point program, the results from the Children's Reinforcement Survey Schedule and verbal report to determine reinforcer preference were integrated into reward selections for the positive point program. Child participants were then asked to select from the generated list of preferred items and activities when they achieve a reinforcement opportunity. Child and adult participants in the traditional treatment control group were not asked to complete a reinforcer preference assessment. Parents were asked to complete the second knowledge check at the end of this session.

### Time-out

Once the positive point program was successfully initiated, time-out was implemented. Parents tracked the number of time-outs given each week, and both the frequency and type of any backup punishers that were required. This typically commenced in the fourth session and continued for the duration of the program. Parents were asked to complete the third knowledge check at the end of this session. The remaining treatment sessions, up to and including the sixth session focused on maintenance issues and strategies for using time-out away from home. During the final session of the parent training program, parents and children once again completed the questionnaires that they were asked to complete during session one.

### Steps Taken to Ensure Uniform Delivery of the Independent Variable

All therapists received standardized training and were required to complete behavioral checklists during training (see Appendix K). All therapists involved in the study were enrolled in an APA accredited doctoral program in clinical psychology. All therapists had previously completed at least one introductory course in therapy skills and theory. Training for therapists included the following: (a) didactic presentation of core concepts from the parenting skills intervention manual by the manual's author; (b) written and oral tests based on the written manual; and (c) role-play of sessions under live supervision conditions. Therapists demonstrated 100% accuracy on mastery checks prior to being qualified to deliver the intervention.

Two forms of manipulation check were used to ensure a minimal level of

uniformity in treatment delivery. First, therapists used behavioral checklists as a manipulation check (see Appendix K) during sessions to monitor their own behavior. The checklists described each step prescribed by the treatment manual and provided a space next to each step that could be checked off upon its completion. Therapists were required to systematically monitor and record whether or not each step was implemented for tracking, positive point and time-out sessions. Manipulation check procedures were obtained from a procedure developed by Harrell and Armstrong (1995).

### Home Observations

To assess parents' use of their newly acquired skills in the home, observers used the skill check forms (see Appendix L). Observers were a graduate student and advanced undergraduate psychology majors who received credit for studies in research skills. Observers were trained using videotape scenarios (see Appendix M for the videotape observer training procedures). On the training scenarios, the observers reached accuracy levels of at least 95% versus ratings provided by an expert who previously coded the training scenarios. For the study, observers coded videotapes alone to assess in-session behaviors. Coding videotape alone minimized possible effects of observer contamination. To ensure the ongoing accuracy of the observers' ratings, inter-observer agreement between observers was computed for each session. Any session coded with less than 95% agreement resulted in retraining of the involved observers and a recording of involved videotapes.

The skills assessment in the home focused on parent recognition of child



compliance and non-compliance, use of rewards and positive points, use of time-out from positive reinforcement, and use of back-up punishers. The assessment of parental skills use took place during three home observations. The observers recorded behavior using the skill check form, a system developed by the authors. One observation was made prior to parents attending any specific training to allow for assessment of baseline skills. The second observation took place when the parents completed the time-out training session. This allowed for observation of all taught skills. The third observation was made two months after completion of the Parent Training Program. Each request a parent made could be followed by a variety of parent responses.

These three assessments excluded data from the first 15 minutes of each observation period in order to decrease assessment reactivity. The observers recorded interactions for the entire hour that they are in the home, but only the final 45 minutes were used. The observation period was chosen by the parents as a time during which they frequently might make several requests of their child, and as the time in which they would be recording the child's compliance and non-compliance rates for use in the parent training sessions. The observers were placed in unobtrusive positions from which they were able to see the majority of family interactions. The only restriction placed on the family during the observation sessions was that they were not to interact with the observer. Observers audio-taped their home visits to facilitate scoring complex interactions. Home observation procedures were obtained from McGrath's Masters thesis proposal (1995).

### Human Participants Protection

All information collected from participants was be treated in accordance with the ethical standards of the American Psychological Association (APA, 1992). Data were collected and stored in a confidential manner. Additionally, informed consent for participants (adult and child) was obtained (see Appendix F, G and H). Results were reported so that no individual was identified.

Participants benefitted from any therapeutic effects derived from participating in the parent training program.

The primary potential risk for participants was that they may have experienced some mild distress when participating in the Parent Training Program and when completing the paper and pencil measures. Additionally, clinical studies suggest that about 25% of families may not show improvement following the intervention (Patterson, 1974). Only HSIRB approved methods were implemented throughout the course of this study.

## RESULTS

The results are presented in five main sections. First, families who completed the study are compared to those who dropped out for child and parent measures, levels of children's baseline compliance and non-compliance, and performance on the knowledge and skills checks. Second, information is provided regarding steps taken to ensure uniform delivery of the independent variable. Third, information is presented for reinforcer preferences. Fourth, experimental and control groups are compared for parent and child measures, for levels of compliance and non-compliance. Finally, data from the home observations and parent evaluation of treatment are presented.

### Completers Versus Non-completers

Twenty-five families enrolled in the study. Fourteen families completed the study. Eleven families dropped out prior to completing the study; all non-completers were families with male children. Only four fathers participated in the study; two dropped out and two completed the study.

### Descriptive Measures for Completers Versus Non-completers

ANOVAs were conducted to assess for possible differences in completers versus non-completers. *P* values were uncorrected in order to provide more conservative tests. An ANOVA revealed that there was no significant age difference between participants

who completed the study and those who did not,  $F(1, 23) = .07, p < ns$ . Similarly, there was no difference in the length of time since the original diagnosis,  $F(1, 23) = .14, p < ns$ . Further, there was no significant difference between children's symptom endorsement on the Children's Depression Inventory,  $F(1, 23) = 1.55, p < ns$ . There were no differences in education levels of those mothers who completed the study (42.6% high school, 28.7% college and 28.7% graduate) and those who dropped out (45.6% high school, 27.2% college, 27.2% graduate). Parent measures between those families who completed the study and those who dropped out were nonsignificant. There were no significant differences between groups on maternal endorsement of symptoms on the Child Behavior Checklist Total T - Score,  $F(1, 21) = .16, p < ns$ , the Externalizing T-Score,  $F(1, 21) = .15, p < ns$  nor the Internalizing T - Score,  $F(1, 21) = .04, p < ns$ . Further, there were no differences between groups for maternal symptom endorsement on the Beck Depression Inventory,  $F(1, 21) = .01, p < ns$ . Further, there were no differences between groups for maternal symptom endorsement on the State-Trait Anxiety Inventory for state or trait anxiety,  $F(1, 21) = .04, p < ns$  or  $F(1, 21) = .09, p < ns$ . Finally, there were no differences in maternal symptom endorsement on the Parenting Stress Index,  $F(1, 21) = .99, p < ns$ . (see Table 1).

There was only one significant difference found. Mothers who dropped out of the study reported significantly more marital dissatisfaction on the Dyadic Adjustment Scale (DAS) than those who completed the study,  $F(1, 17) = 7.71, p < .01$ . Close inspection of the data did not reveal that this difference was the result of an outlier. An insufficient number of fathers returned the questionnaires, so the implications of this data are unclear.

Table 1  
Comparisons Between Completers and Non-completers  
for Child and Parent Variables

All p values for this table were nonsignificant with the exception of the DAS.

	Completers		Non-completers	
Variable	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Age	8.9	1.7	9.0	1.8
Diagnostic Duration	29.4	22.8	32.2	12.2
CDI	7.7	6.2	12.6	12.9
CBCL (Total T- Score)	68.2	7.9	69.8	6.2
CBCL (Externalizing T-Score)	69.8	6.2	68.4	10.4
CBCL (Internalizing T-Score)	63.7	6.7	66.7	8.6
BDI	7.1	6.5	7.3	6.1
STAI (State)	39.5	10.7	38.6	11.9
STAI (Trait)	39.7	10.6	38.2	12.2
DAS	94.0*	10.6	80.2	11.1

Table 1 - Continued

Variable	Completers		Non-completers	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
PSI	301.0	30.6	319.8	60.2

\* $p < .05$

#### Compliance and Non-compliance Levels for Completers Versus Non-completers

There were no differences between groups for maternal report of child compliance,  $F(1, 18) = .25$ ,  $p < ns$  and child non-compliance,  $F(1, 18) = .15$ ,  $p < ns$  at baseline. However, participants who completed the study had a significantly greater frequency of non-compliances during home observations than those who dropped out,  $F(1, 18) = 4.31$ ,  $p < .05$ , but home observations of child compliance,  $F(1, 18) = .35$ ,  $p < ns$  was not significant (see Table 2). When proportions for the same data were reported, there was an approximately 18% difference between completers and non-completers for both home observations of compliance and non-compliance with non-completers having increased compliance and decreased non-compliance when compared to completers (see Table 3). Note that data from the home observation scores and the parent reports are not to be compared directly as they come from separate observation samples. The home observation is based on a 45 minute sample while weekly parent reports are usually based on 7 one - hour samples.

### Knowledge Check and Skills Check

Participants who completed the study were also compared to non-completers on the knowledge check and the skill check. For the knowledge check, those who completed received a mean score of 9% pre-treatment for quiz one, 12.7% for quiz two, and 4.5% for quiz three. A score of 5% was obtained by those who dropped out on the knowledge check pre-treatment quiz one, 21% on quiz two and 7% on quiz three.

Table 2

Comparisons for Completers Versus Non-completers for Maternal Reports and Home Observations of Child Compliance and Non-compliance (Frequencies Reported)

Variable	Completers		Non-completers	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Totals for Parent Report of Child Compliance for Tracking Week	17.1	12.8	14.3	6.8
Totals for Parent Report of Child Non-compliance for Tracking Week	33.6	21.3	28.8	33.2
One Day Report for Home Observation of Child Compliance	11.5	6.2	9.6	8.2
One Day Report for Home Observation of Child Non-Compliance	11.6	9.5	4.4	4.3

For the pre-treatment skill check, results were also non-significant when comparing completers to non-completers. Participants who completed were observed to have 61.3% compliance and those who did not complete to have 66.4% compliance. Also, participants who completed made an average of 20.9 requests during the observation hour, while those who did not complete made an average of 21.5 requests during the observation hour. None of the comparisons between participants who completed and those who dropped out yielded significant results, indicating that completers and non-completers were equivalent on pre-treatment measures.

Table 3

Comparisons for Completers Versus Non-completers for Maternal Reports and Home Observations of Child Compliance and Non-compliance (Proportions Reported)

Variable	Completers	Non-completers
Totals for Parent Report of Child Compliance for Tracking Week	33.7%	33.2%
Totals for Parent Report of Child Non-compliance for Tracking Week	66.3%	66.8%
One Day Report for Home Observation of Child Compliance	49.8%	68.6%
One Day Report for Home Observation of Child Non-Compliance	50.2%	31.4%



### Steps Taken to Ensure Uniform Delivery of the Independent Variable

Two forms of a manipulation check were used in this study. First, therapists used checklists to document that the intervention was delivered as stated by the treatment manual. Therapist self-report for adherence to the treatment manual was 99.6% for the tracking session, 99.7% for the positive point program and 99.8% for the time-out session. Second, a random selection of 20% of were videotaped. These eight sessions included three tracking, three positive point program and two time-out sessions. Results of the sampling revealed a .93 reliability with steps prescribed by the treatment manual.

### Reinforcer Preference for the Experimental Group

In order to test the main hypothesis, it was important to document that parents in the experimental group actually used the reinforcers identified a priori by their children. In the experimental group, all rewards used in the positive point program were identified as reinforcers by the child participants. This served as a manipulation check and suggested that parents used what their children identified as preferences, even when these choices sometimes conflicted with their own beliefs of what their children's preferences would be. Note that while reinforcers could have been selected from either the reinforcer survey or the interview's open list for reinforcer preference, the open list for reinforcer preference was utilized more frequently in the positive point program than items identified on the fixed list from the reinforcer survey.

### Descriptive Measures for the Experimental Group Versus Control Group at Pre-Test

The fourteen families who completed the study were involved in the final analyses. Through random assignment, there were three boys and four girls in the experimental group and six boys and one girl in the traditional treatment control group. An ANOVA revealed no differences for age between the experimental group and the traditional treatment control group,  $F(1, 12) = .22$ ,  $p < ns$  nor were there any significant differences for length of time since the original diagnosis,  $F(1, 12) = .03$ ,  $p < ns$ . There was no significant difference between children's symptom endorsement on the Children's Depression Inventory,  $F(1, 12) = .88$ ,  $p < ns$ .

ANOVAs did not demonstrate any between group differences for maternal endorsement of symptoms on the Child Behavior Checklist (CBCL) Total T - Score,  $F(1, 12) = 2.6$ ,  $p < ns$ , the Externalizing T - Score,  $F(1, 12) = 2.6$ ,  $p < ns$  and the Internalizing T - Score,  $F(1, 12) = 2.9$ ,  $p < ns$ . ANOVAs revealed no significant differences between groups for either maternal endorsement of symptoms on the Beck Depression Inventory,  $F(1, 12) = 1.4$ ,  $p < ns$ . Further, ANOVAs revealed no significant differences between groups for either maternal endorsement of symptoms on the STAI for state or trait anxiety,  $F(1, 12) = .85$ ,  $p < ns$  or  $F(1, 12) = .81$ ,  $p < ns$ . Finally, there was no significant difference between groups on the Parenting Stress Index,  $F(1, 12) = 1.9$ ,  $p < ns$ . Mothers in the experimental group reported somewhat greater marital satisfaction than those in the control group,  $F(1, 8) = 4.8$ ,  $p < .06$  (see Table 4).

Maternal Report of Compliance and Non-compliance Levels  
for the Experimental Versus Control Group

Maternal report of child compliance and non-compliance prior to treatment was nonsignificant between groups,  $F(1, 12) = 1.7$ ,  $p < ns$  and  $F(1, 12) = 2.4$ ,  $p < ns$ , respectively. Group differences were also nonsignificant for compliance and non-compliance following the positive point program,  $F(1, 11) = .09$ ,  $p < ns$  and  $F(1, 11) = 2.7$ ,  $p < ns$ , respectively. Maternal report of child compliance following the time-out session was also nonsignificant,  $F(1, 11) = .10$ ,  $p < ns$ . However, there were group differences between maternal reports of non-compliance following time-out,  $F(1, 11) = 6.6$ ,  $p < .02$ . (see Figures 1, 2, 3 & 4).

Table 4

Group Differences Between the Experimental Group and the Traditional Treatment Control Group at Pre-Test

All p values were non-significant with the exception of the DAS.

Variable	Experimental Group		Control Group	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Age	8.6	1.9	9.1	1.5
Diagnostic Duration	28.3	22.4	30.4	24.9
CDI	9.3	7.4	6.1	4.8
CBCL (Total T- Score)	71.4	7.7	65.0	7.1

Table 4 - Continued

Variable	Experimental Group		Control Group	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
CBCL (Externalizing T-Score)	72.1	5.3	67.4	6.5
CBCL (Internalizing T-Score)	66.7	7.7	60.9	4.5
BDI	9.1	7.1	5.1	5.6
STAI (State)	42.1	11.9	36.9	9.5
STAI (Trait)	42.3	11.0	37.1	10.2
DAS	101.5*	9.7	89.0	8.3
PSI	290.0	19.4	312.0	37

\* $p < .05$ 

Home Observations of Compliance and Non-compliance Levels  
for the Experimental Versus Control Group

At baseline, prior to any treatment implementation, ANOVAs demonstrated no group differences in observed child compliance,  $F(1, 9) = .51$ ,  $p < ns$  or non-compliance levels,  $F(1, 9) = .52$ ,  $p < ns$  during home observations. Following the time-out session, ANOVAs demonstrated no group differences in observed child compliance,  $F(1, 8) = .09$ ,  $p < ns$ , but significance was approached for non-compliance levels during home

observations,  $F(1, 8) = 3.9$ ,  $p < .08$  with an increased frequency of non-compliance observed in the experimental group. At the two month follow up, ANOVAs again demonstrated no group differences in observed child compliance,  $F(1, 8) = .70$ ,  $p < ns$  or non-compliance levels,  $F(1, 8) = 1.1$ ,  $p < ns$  (see Tables 5 & 6). Note there were no group differences for the average number of sessions.

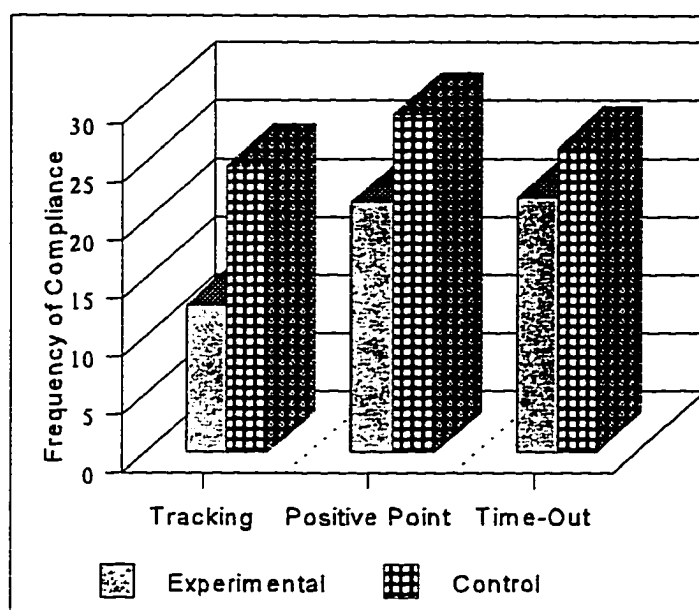


Figure 1. Weekly Parent Report of Child Compliance for Experimental and Control Groups (Frequency).

### Nonparametric Analyses

#### Descriptive Measures for the Experimental Group and Control Group

A Mann Whitney U test was conducted to examine change scores for child symptom endorsement on the Child Depression Inventory (CDI) between groups. There was no group difference for CDI change scores between baseline and following

implementation of the parenting strategies program,  $\underline{U}(1, 12) = -.19, p < ns$ .

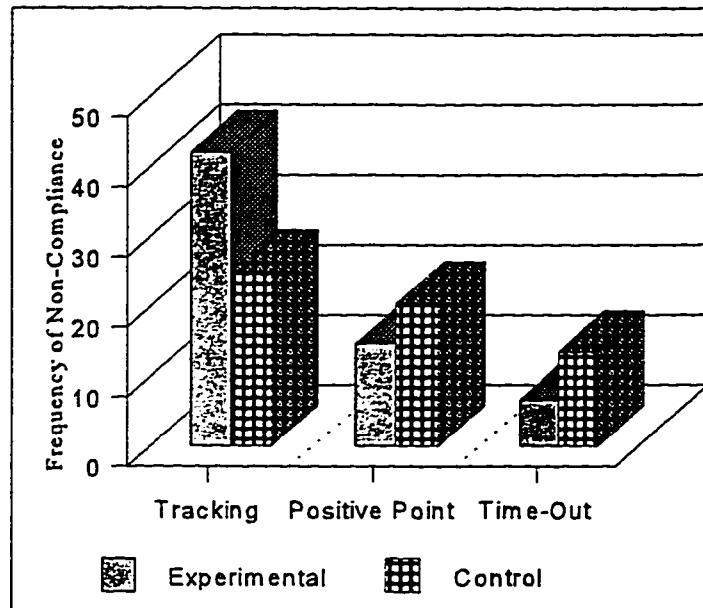


Figure 2. Weekly Parent Report of Child Non-Compliance for Experimental and Control Groups (Frequency).

A Mann Whitney U test was conducted to examine change scores for maternal symptom endorsement on the Child Behavior Checklist (CBCL) between groups. There were no group differences for CBCL Total - T, Externalizing - T and Internalizing - T change scores between baseline and following implementation of the parenting strategies program,  $\underline{U}(1, 12) = -.32, p < ns$ ,  $\underline{U}(1, 12) = -.19, p < ns$  and  $\underline{U}(1, 12) = -.06, p < ns$  respectively. A Mann Whitney U test was conducted to examine change scores for maternal symptom endorsement on the Beck Depression Inventory (BDI) between groups. There were no group differences for BDI change scores between baseline and following implementation of the parenting strategies program,  $\underline{U}(1, 12) = -.29, p < ns$ .

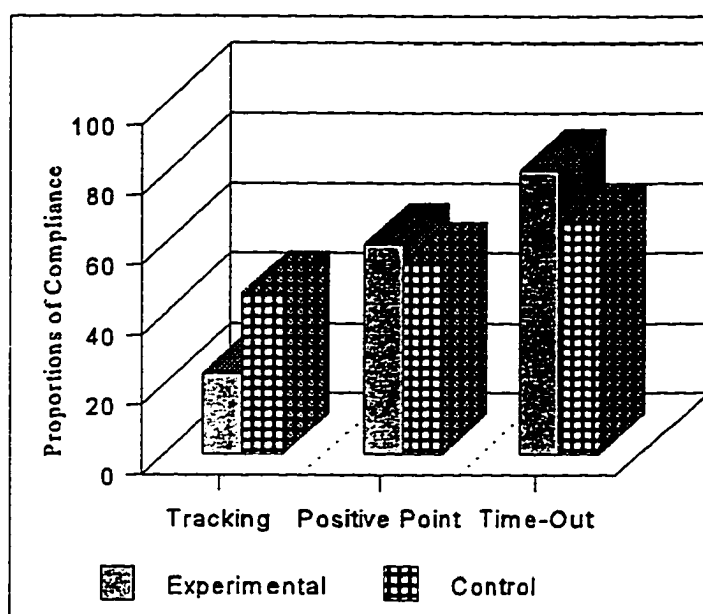


Figure 3. Weekly Parent Report of Child Compliance for Experimental and Control Groups (Proportions).

A Mann Whitney U test was conducted to examine change scores for maternal symptom endorsement on the State-Trait Anxiety Inventory (STAI) between groups. There were no group differences for STAI State and Trait change scores between baseline and following implementation of the parenting strategies program,  $U(1, 12) = -1.42, p < ns$  and  $U(1, 12) = -.26, p < ns$ .

A Mann Whitney U test was conducted to examine change scores for maternal symptom endorsement on the Dyadic Adjustment Scale (DAS) between groups. Significance was approached for DAS total change scores between baseline and following implementation of the parenting strategies program,  $U(1, 12) = -1.78, p < .07$ . The mean change score between groups was  $M = 6.0$  ( $SD = 1.5$ ) for the experimental group and  $M$

= 1.5 ( $SD = 0.5$ ) for the control group.

A Mann Whitney U test was conducted to examine change scores for maternal symptom endorsement on the Parenting Stress Index (PSI) between groups. There were no group differences for PSI change scores between baseline and following implementation of the parenting strategies program,  $U(1, 12) = -1.01$ ,  $p < ns$ .

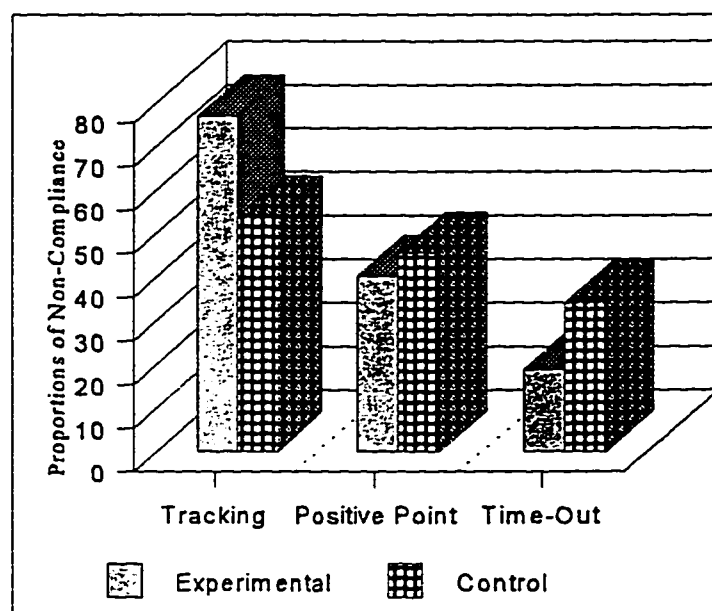


Figure 4. Weekly Parent Report of Child Non-Compliance for Experimental and Control Groups (Proportions).

#### Compliance and Non-Compliance Levels

A Mann Whitney U test was conducted to examine change scores for maternal report of child compliance and non-compliance between groups. There were no group differences for compliance level changes between tracking and following implementation



of the positive point program,  $U(1, 12) = -1.4$ ,  $p < ns$ ). There was a significant group difference for maternal report of compliance level changes between tracking and following implementation of time-out,  $U(1, 12) = -2.2$ ,  $p < .03$ . The mean change score between groups was  $M = 29.1$  ( $SD = 13.4$ ) for the experimental group and  $M = 26.2$  ( $SD = 21.0$ ) for the control group.

Table 5

## Home Observation Frequencies of Child Compliance and Non-compliance

Variable	Experimental Group		Control Group	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Home Compliance (Baseline)	13.3	5.4	10.4	6.7
Home Non-compliance (Baseline)	8.8	7.6	13.1	10.6
Home Compliance (Post time-out)	8.8	4.8	7.8	4.9
Home Non-compliance (Post time-out)	6.5	2.4	3.5	2.4
Home Compliance (2 month follow-up)	8.3	4.6	6.3	2.7
Home Non-compliance (2 month follow-up)	6.8	5.6	4.3	1.4

Table 6

## Home Observations Proportions of Child Compliance and Non-compliance

Variable	Experimental Group	Control Group
Home Compliance (Baseline)	60.1%	44.3%
Home Non-compliance (Baseline)	39.9%	55.7%
Home Compliance (Post time-out)	57.5%	69.0%
Home Non-compliance (Post time-out)	42.5%	31.0%
Home Compliance (2 month follow-up)	54.9%	59.4%
Home Non-compliance (2 month follow-up)	45.1%	40.6%

Significance was approached for non-compliance level changes between implementation of the positive point program,  $U(1, 12) = -1.8$ ,  $p < .07$  and following implementation of time-out,  $U(1, 12) = -1.5$ ,  $p < .09$ . The mean change score between groups was  $M = 6.7$  ( $SD = 1.5$ ) for the experimental group and  $M = 13.5$  ( $SD = 6.9$ ) for the control group.

A Mann Whitney U test was conducted to examine change scores for home observations of child compliance and non-compliance between groups. There was not a significant difference for home observations of compliance and non-compliance level

changes between baseline and following implementation of the parenting strategies program,  $U(1, 12) = -1.38$ ,  $p < ns$ . Group differences for compliance and non-compliance level changes at a two month follow up were also nonsignificant,  $U(1, 12) = .00$ ,  $p < ns$  and  $U(1, 12) = -1.1$ ,  $p < ns$  respectively.

There were no between group differences for the frequency of time-outs (experimental group  $M = 4.5$ ; control group  $M = 4.7$ ) or back-up punishers (experimental group  $M = 1.0$ ; control group  $M = 1.2$ ) used during the time-out session.

### Knowledge Check

Results from the knowledge check assessments demonstrated that parents did gain a considerable amount of parenting knowledge that was largely maintained at follow-up. Percentages of correct responses on each of the three quizzes at pre-treatment, post-treatment and follow-up are presented in Table 7.

An item analysis was completed to study the possible causes of somewhat limited maintenance of information covered on knowledge check 3 at follow-up. Results indicated that participants had a difficult time with questions 6 and 10 which requires parents to identify the importance of offering the child one last chance to choose between serving a ten minute time-out or being assigned the back-up punisher.

### Skill Check

Results of this measure were originally intended to be reported in percentage of correct parent behaviors observed at pre-treatment, post-treatment and follow-up.

However, the frequency of observing any completely correct parenting behaviors taught in the parenting skills program was very low. For example, of the 22 home observations made post-treatment and follow-up, on only 9 occasions, was any completely correct parent behavior from the program actually observed. Parents were observed attempting to implement some form of the skills taught during the parenting program for approximately 12% of the parent-child interactions.

Table 7

## Percentage of Correct Parent Responses on the Knowledge Checks

Variable	Pre-treatment (% correct)	Post-treatment (% correct)	Follow-up (% correct)
Knowledge Check 1	0%	98%	95%
Knowledge Check 2	6%	91%	80%
Knowledge Check 3	2%	94%	69%
Total % Correct	2%	94%	81%

The most commonly observed correct parent behaviors were the same for post-treatment as for follow-up. These three behaviors were using the timer correctly, giving the initial time-out correctly, and ending time-out correctly. Parents were never observed to assign a back-up punisher correctly out of two attempts. The most frequent parent

errors observed during the home observations were the same for post-treatment as they were for follow-up. These errors included not recording the child's behavior, giving the initial time-out incorrectly, adding minutes incorrectly and ending time-out incorrectly. Anecdotal reports by the observers indicated that parents also demonstrated significant problems in issuing clear requests.

### Parent Evaluation of Treatment

Results of the parent evaluation of treatment indicated that parents were satisfied with the overall parenting program and believed that it did help their parenting. Further, they indicated that both the home observations and the knowledge quizzes were useful. Parent reported that there was a decrease in the amount of negative time they spent with their child and an increase in positive time. Finally, parents indicated overwhelmingly that they would recommend the program to other parents.

## DISCUSSION

The discussion is presented in five main sections. First, data related to non-completers will be reviewed. Second, the accuracy of treatment delivery is presented. Third, broad treatment effects and an evaluation of the primary hypothesis are addressed. Fourth, benefits, limitations and future directions of the research are discussed. Finally, a brief conclusion is provided.

### Non-completer Rate

Eleven of the twenty-five participants who enrolled in the study did not complete their involvement. Many published parent training studies do not address the issue of attrition (e.g., Erhardt & Baker, 1990; Henry, 1987; Webster-Stratton, 1989; Sloane, Endo, Hawkes & Jenson, 1991). However, in studies where attrition is addressed, dropout rates vary from approximately 20% through 40% (Anastopoulos, Shelton, DuPaul & Guevremont, 1993; Horn, Ialongo, Greenberg, Packard & Smith-Winberry, 1990; Horn, Ialongo, Pascoe, Greenberg, Packard, Lopez, Wagner & Puttler, 1991; Horn, Ialongo, Popovich & Peradotto, 1987; Webster-Stratton, 1984). Based upon what is reported in the literature, the 44% dropout rate in this study is comparable to the highest dropout rates published to date. It is unclear if the obtained dropout rate would appear more typical if compared to unpublished studies as well. Further, the definition for non-completers used in this study was liberal and it is unclear how non-completers

have been defined in published studies.

Preliminary analyses of this study did not suggest that dropout rates could be accounted for by demographic or subject variables as there were no significant differences between completers and non-completers. The only exception was that non-completers reported significantly greater marital distress than completers. Visual analysis suggests that this result did not appear to be the consequence of outlier scores. One family who did not complete the study was referred for marital therapy following the second treatment session. Prior research also indicates a greater likelihood of noncompletion in the presence of marital distress (Reisinger et al., 1976; Webster-Stratton, 1985a) and suggests that marital satisfaction should be addressed for some families prior to implementing a parenting strategies program.

Maternal reports of compliance and non-compliance over a one week baseline period indicated there were no differences between those participants who completed the study and those who did not. However, this was discrepant with the brief (one hour) home observations which demonstrated a relatively small (18%), but statistically significant greater compliance rate for non-completers. This finding suggests that those participants who completed the study may have had a somewhat greater need for the parenting strategies program, given the difference observed during the home observations. However, it should be emphasized that these results were based on a small sample of target behavior.

Prior analyses of attrition have hypothesized that participants may dropout for three reasons: (1) random assignment to treatment, (2) dissatisfaction with treatment

efficacy, or (3) insufficient time to complete the program requirements and/or concerns about the use of medication (Ialongo, Pascoe, Greenberg, Packard, Lopez, Wagner & Puttler, 1991). Anecdotal report from this study's non-completers suggest some individuals who dropped out because of the amount of time the program required of participants. Even those participants who completed the study would often need to delay treatment sessions because of failing to complete between session assignments which prevented the therapist from initiating the next treatment component. Further, some individuals who dropped out reported dissatisfaction with the treatment program and/or treatment efficacy. In several cases, it was reported that the partner who chose not to participate expressed that there would be no benefits to be gained from participating in the program. Several of the parents who initially participated disagreed with rewarding their child for good behavior or the specific form of time-out recommended in this program (e.g., one parent believed that time-out should only involve sending the child to their room to calm himself/herself down). One additional factor that may have contributed to the somewhat higher dropout rate was the utilization of student therapists rather than senior clinicians.

In contrast to other studies, concerns about the use of medication and random assignment to group were not believed to contribute to the dropout rate found in this study, for several reasons. First, medication was not a component of the treatment protocol (i.e., no manipulation of medication took place) nor were there any reported changes in medication status during the course of the study. Second, the perceived difference between the group treatment protocols for parents was small, unlike studies



where parents provide consent to the experimenter to control the child's medication status.

Several changes might aid in reducing the dropout rate in the future. It is recommended that future studies: (a) provide an in depth discussion of the program rationale (e.g., some parents have reservations about providing children with tangible rewards, but if parents were provided with an explanation early on, it may help alleviate their concerns); (b) provide parents with detailed descriptions of in-between session homework, the time commitment involved, and establish that other parents have found the investment to be worth it; (c) set expectations about child involvement; (d) increase flexibility with the training manual; (e) be explicit in the availability of additional outpatient therapy (e.g., marital); (f) involve a level of payment by the client; and (g) possibly utilize only senior clinicians.

#### Accuracy of Treatment Delivery

According to Addis & Carpenter (1997), there are mixed reactions to the use of treatment manuals in behavior therapy. It has been argued that treatment manuals reduce therapy to a set of rules and hinder clinical judgement. Further, adherence to a treatment manual may reduce sensitivity to changing contingencies during the therapeutic process. In clinical practice, individuals are likely to present with multiple problems which may also not be addressed sufficiently within the scope of a treatment manual. However, it has also been argued that basing treatment on clinical judgement alone may not always lead to the most effective treatment decisions. Nevertheless, in this study it was important that a

standardized protocol be closely followed because only a relatively minor change to the protocol was being evaluated. Also, treatment manuals may play a strong role in training less experienced therapists.

Overall, treatment was delivered as stated in the treatment manual. Therapists' self-report for adherence to the manual was 99.7% across the three treatment sessions. Twenty percent of the video tapes were coded to evaluate therapists' actual adherence and revealed a .93 reliability with the treatment manual. This demonstrates strong adherence to the treatment manual and indicates that the behavior checklist is a valid indicator for assessing what actually took place in session. Further, there were no noted differences between reliability for somewhat more experienced versus less experienced clinicians. However, a subjective review of the checklists suggested that the less experienced clinicians followed the sequence of the behavior checklist more closely whereas the somewhat more experienced clinicians still covered the essential points, though in a less rigid manner.

The lack of differences for treatment delivery for different levels of experience across graduate student therapists may be the result of the specific operational definitions used during the parent training program. These specific operational definitions functioned to effectively train inexperienced therapists. Further, adherence to the treatment manual allowed for increased standardization of treatment delivery which minimized the influence of therapist variables and may have functioned to more clearly demonstrate the proposed treatment effect. It may also be the case that there would be differences for the graduate student therapists versus senior post degree therapists in treatment effectiveness.

However, this was untested in this study. Another aspect of accurate treatment delivery was whether parents in the experimental group used reinforcers that were identified a priori by their children. A manipulation check showed that children's preferences were used 100% of the time during the Positive Point Program.

### Broad Treatment Effects

The overall treatment results of this study reflect what has been reported in the literature demonstrating the benefits of parent training. This Patterson based parenting strategies program, which was implemented over 6-8 weeks and included three principle sessions (tracking, positive point program and time-out), targeted behavior change and assessment of that behavior change. Overall treatment effects across groups demonstrated significantly increased compliance levels and significantly decreased non-compliance levels according to maternal report at post treatment. Overall, parents who completed the program expressed satisfaction (i.e., they reported increased positive interactions and decreased negative interactions with their child).

Contrary to the weekly maternal reports, no treatment benefits were confirmed during the brief home observations. This discrepancy in the results may have occurred for several reasons: (a) only a limited sample of home observations was possible (i.e., one hour for each pre-treatment, post-treatment and the two month follow-up) and may not have been a representative sample of what occurred in the home; (b) parents and/or children may have been reacting to the observer when the home observations were conducted; (c) parents may have been hesitant to engage in some of the behaviors that

were more difficult to learn (e.g., parents were never observed to give a back-up punisher correctly; this behavior was observed only twice in all home observations); (d) parents experienced difficulty adding minutes during the time-out protocol (this behavior was also only observed twice during home observation); (e) parents may have been noncompliant with the treatment protocol (e.g., parents may have completed the behavior tracking sheets incorrectly to present themselves in a good light to their respective therapists and, thus, could be one possible explanation for treatment failure); and (f) parents may have perceived that their child was engaging in more of the target behavior given their expectations of treatment outcome (i.e., "I'm participating in this program therefore I know my child will mind me more").

Unlike previous studies (e.g., Anastopoulos et al., 1993) which have noted global improvements in child and parent functioning, no statistically significant global improvements in functioning were noted beyond increases in the targeted compliance behaviors. It is unclear why this occurred given the overall treatment effects and the parents' positive evaluation of the treatment program. However, the small number of participants who completed the study could have accounted for the absence of statistically significant gains on global measures.

### Evaluation of the Primary Hypothesis

Between groups analyses provide preliminary support for conducting an assessment of children's preferences prior to implementing this particular parenting program. Addition of this component appears to enhance the strength of the treatment

effects. This is consistent with previous research studies conducted with different populations, which have suggested a priori reinforcer assessments can enhance behavioral interventions in general (Houlihan et al., 1990). Further, this may be one explanation for the reported treatment failure for families who have participated in parent training programs (i.e., failure to promote behavior change may be the result of poor stimulus selection rather than the mismanagement of contingencies).

In the traditional implementation of the Patterson based parent training program, parents' beliefs about their child's preferences are relied upon during the Positive Point Program rather than conducting an assessment with the child specifically. However, the results of this study highlight the potential added value of conducting an assessment with the child specifically. Interestingly, parents' beliefs of their children's preferences matched their child's actual preferences approximately 33% of the time during the Positive Point Program. This demonstrates a large discrepancy between the child's actual report of preferences and parents' guesses. This is consistent with Miller, Davis, Wilde & Brown's (1993) results, which demonstrated only moderate accuracy between parents' predictions of their child's preferences and the child's self-report. Importantly, parents in this experimental group used the children's actual preferences in this study and this seemed beneficial.

Note also that the open list was relied on more heavily by parents than the reinforcer survey (a checklist) when establishing what potential reinforcers were to be implemented in the Positive Point Program. On average, five reinforcers (of the six listed by parents on their weekly charts) were used from the open list while only one came from

the formal reinforcer survey. This heavy reliance on the open list may have resulted from characteristics of the rewards listed on the reinforcer survey. First, the reinforcer survey did not address many of the more modern rewards that children spontaneously identified as wanting to earn (i.e., Nintendo, renting a movie). Second, some of the items were those that the child could be expected to receive regularly regardless of their behavior (i.e., milk, fruit, someone to take care of you when you are sick). Third, a number of items on the reinforcer survey were not items that the parents could guarantee as reinforcers (e.g., talk to a movie star or sports star) and were thus excluded from possible use during the positive point program.

### Implications of Findings

#### Strengths Related to Internal Validity

An apparent strength of the current study is the minimization of several potential threats to internal validity. First, due to the strict selection criteria utilized (wherein only participants meeting the criteria for ADHD with oppositional behaviors were included in the study), pre-existing behavioral and/or diagnostic differences were minimized. Therefore, the probability that the resulting differences were due to pre-existing conditions, as opposed to manipulation of the independent variable, was reduced.

Second, significant differences between groups at baseline were not found for demographic variables, with the exception of gender. There were four girls in the experimental group and only one in the control group as a result of random assignment to groups. Despite this threat to internal validity, its impact is believed to be minimized

for the following reasons: (a) there were no differences between girls and boys with respect to severity of symptom endorsement by parents (i.e., all participants were diagnosed with ADHD with oppositional behaviors); (b) all participants were currently prescribed stimulant medication; and (c) there were no gender differences for compliance and non-compliance levels at baseline.

A third strength related to the internal validity of this study involves the finding that there were no differences between the experimental and control groups for the frequency of time-outs or back-up punishers used. This finding minimizes the possibility that differences in these variables account for the reported differences in non-compliance levels between groups.

A further strength of this study was the consistency of treatment delivery. The use of the behavior checklist during each treatment session functioned as a measure of adherence to the treatment manual and demonstrated the checklist to be a valid instrument for assessing what took place in session. This manipulation check is rarely used in treatment studies and, consequently, more inferences may have to be made about the reliability of treatment delivery and the validity of results.

### Clinical Implications

The clinical implications of this study are as follows. Results indicate that conducting a reinforcer assessment prior to implementing this parent training program may enhance its effectiveness. Further, the reinforcer assessment is quickly and easily administered and may increase involvement of the child in the assessment procedure and

thereby strengthen the therapeutic relationship with the overall family. In contrast, the traditional implementation of the program involves the child only minimally and the child has little or no contact with the therapist.

The results of this study support previous findings which indicate the added value of conducting a reinforcer assessment prior to implementing a behavior treatment program (Green et al., 1991; Houlihan et al., 1990). Results also further clinical research by indicating the potential effectiveness of the reinforcer assessment with an ADHD population and within the larger context of parent training programs.

### Limitations

Caution must be used when interpreting the results of this study for several reasons. First, obtaining positive results with a small sample size can only suggest that there may be a benefit to conducting a reinforcer assessment with the child prior to implementing this particular parent training program. Sample size was smaller than desired, despite rigorous recruitment efforts. This may have been an effect of a general belief in Southwest Michigan that adjunct non-pharmacological treatment approaches are no more effective than pharmacological treatment for ADHD children.

Second, it has been suggested by Moncher and Prinz (1991) that the accuracy and reliability of treatment delivery may be further enhanced by live supervision in addition to a clear and concise treatment manual. However, given the practical limitations (i.e., limited supervision time, a video camera not available, human error when using the video camera), not all sessions were observed or videotaped. This criteria does not seem



relevant given that with a representative sample of approximately 20% of the sessions data indicated high agreement between therapist self-report and independent confirmation of adherence to the treatment protocol. However, it is unknown what influence live supervision, 100% videotaping, or the absence of both these factors would have on therapist's adherence rates.

A third limitation of this study was the heavy reliance on parent self-report rather than on actual behavioral observations. Home observations, though conducted, were based on a very small sample of behavior. Because of this limited sample it is difficult to know whether parents consistently generalized the skills taught within the treatment sessions.

#### Future Directions

Future research should focus on conducting a larger scale study (i.e., larger sample size with more home observation sessions), in order to more conclusively test the study's primary hypothesis. An additional benefit of a larger sample size is that randomization to groups would likely eliminate potential pre-test group differences, greatly simplifying the interpretation of results.

Future research might also attempt to increase the generalizability of conducting a reinforcer assessment by applying the protocol to other parent training programs (e.g., Barkley, 1990). The parent training program used in this study was brief and utilized only three basic components. Different parent training programs may include additional components and/or be longer in duration. For example, therapists who participated

unanimously agreed that a component should be included in order to address clear and effective approaches to request making.

Future studies should also focus on further evaluating the role of self-report versus actual observations of the children's target behavior. Currently, the degree and accuracy with which parents translate the parenting skills taught in session to the home setting is unclear. Given that discrepancies exist between self-report and observed behavior, a larger sample of behavioral observations outside of the clinic may function to assess what actually does occur between sessions. This would lead to more conclusive treatment results.

### Conclusions

The results of this study are consistent with previous research that supports the importance of assessing reinforcer preference prior to implementing a behavioral intervention. This study has addressed the use of this technique with a specific diagnostic population and within the context of a parent training program. As this is the first study to simultaneously examine these procedures, further research is warranted to draw more conclusive results. However, as preliminary data, the results of this study are promising.

**Appendix A**  
**Subject Recruitment Flyer**

*Attention Parents -*

Page 2

Page 3

**IS YOUR 6-12 YEAR OLD CHILD  
DEMONSTRATING  
NONCOMPLIANT, DEFIANT, OR  
OPPOSITIONAL BEHAVIORS?  
  
DOES YOUR CHILD ALSO HAVE  
A HISTORY OF BEING  
PRESCRIBED  
PSYCHOSTIMULANT  
MEDICATION?**

In conjunction with the Psychology Department at Western Michigan University, we are conducting a study aimed at investigating the effectiveness of a 6 to 8 session intervention which focuses on teaching parents systematic strategies for increasing child compliance to parent requests and decreasing defiant, noncompliant, or oppositional behavior. Sessions will be scheduled so that all parents living at home can attend. Therapists will all be advanced students from the clinical psychology doctoral program.

Normal training clinic charges are waived for subjects meeting inclusion criteria (training clinic fees are normally \$20 a session with a sliding fee scale available for those with financial need). The program will be offered 1995-1996.

If you would like additional information about participating in this program, please contact:

**Dr. Kevin J. Armstrong**  
Assistant Professor  
Clinical Psychology Training Program  
(616) 387-8311

at

The Psychology Department  
Western Michigan University  
Kalamazoo, MI 49008-5052

**Appendix B**  
**Child's Reinforcer Preference Survey**

## Part A

**Directions:**

This is a list of many different things or activities. Explain how much you like each choice by making an "X" in the appropriate box.

If you dislike the choice, make an "X" in the box under Dislike:

		Like Very Much
Dislike	Like	
X		

If you like the choice, make an "X" in the box under Like:

		Like Very Much
Dislike	Like	
	X	

If the choice is something which you like very, very much, make an "X" in the box under Like Very Much:

		Like Very Much
Dislike	Like	
		X

	Dislike	Like	Like Very Much
1. Do you like candy?			
2. Do you like raisins?			
3. Do you like milk?			
4. Do you like stuffed toy animals?			
5. Do you like coloring?			
6. Do you like making things out of clay?			
7. Do you like listening to music?			
8. Do you like animal stories?			
9. Do you like playing on swings?			
10. Do you like kickball?			
11. Do you like going on field trips at school?			
12. Do you like being the teacher's helper?			
13. Do you like going to the library?			
14. Do you like people to tell you that you did a good job?			
15. Do you like your teacher to buy materials that you especially like?			
16. Do you like teaching things to other people?			

	Dislike	Like	Like Very Much
17. Do you like watching trucks, bulldozers, and tractors?			
18. Do you like to go shopping?			
19. Do you like to eat out in a restaurant?			
20. Do you like going to a circus or a fair?			
21. Do you like playing with dogs?			
22. Do you like to play with some children younger than you?			
23. Do you like to play with some special grown-ups?			
24. Do you like people to take care of you when you are sick?			
25. Do you like taking care of pet animals?			

Verbal Report:

**Directions:**

This is a list of many different things or activities. Explain how much you like each choice by making an "X" in the appropriate box. 64

If you dislike the choice, make an "X" in the box under Dislike:

		Like Very Much
Dislike	Like	Much
X		

If you like the choice, make an "X" in the box under Like:

		Like Very Much
Dislike	Like	Much
	X	

If the choice is something which you like very, very much, make an "X" in the box under Like Very Much:

		Like Very Much
Dislike	Like	Much
		X

	Dislike	Like	Like Very much
1. Do you like candy?			
2. Do you like fruit?			
3. Do you like cooking?			
4. Do you like to drink soda?			
5. Do you like to make models?			
6. Do you like to play with model cars and trains?			
7. Do you like to draw and paint?			
8. Do you like to do crafts?			
9. Do you like carpentry and woodworking?			
10. Do you like making things out of clay?			
11. Do you like working with motors?			
12. Would you like to have sports equipment of your own?			
13. Do you like to play on playground equipment?			
14. Do you like to go bike riding?			
15. Do you like to go swimming?			
16. Do you like to go skiing?			
17. Do you like hockey?			
18. Do you like baseball?			



	Dislike	Like	Like Very Much
55. Do you like being alone rather than being with other people?			
56. Would you like to talk to a sports' star you know about?			
57. Would you like to talk to a TV or movie star you have seen?			
58. Do you like going to parties?			
59. Do you like to stay overnight at a friend's house?			
60. Do you like earning money?			
61. Do you like it when your teacher buys materials that you especially like?			
62. Do you like to be praised for your good work?			
63. Do you like your parents to ask you what you did in school today?			
64. Do you like to be the winner of a contest?			
65. Do you like to have your teacher ask you to help?			
66. Do you like getting the right answer?			
67. Do you like to show your good work to other people?			
68. Do you feel good when you have just finished a project or job you had to do?			
69. Do you like it when all the other kids think you are terrific?			
70. Do you like taking care of pet animals?			
71. Do you like fixing broken things?			
72. Do you like having a birthday party and getting presents?			
73. If your friend is sick, do you like to take some things to your friend's house to make your friend feel happier?			
74. Do you like someone to take care of you when you are scared?			
75. If you are sick, do you like people to take care of you?			

6. What do you think is the best thing about you?

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7. What do you daydream about?

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---



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8. What do you do for fun?

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---

79. What would you like for your birthday?

66

80. Do you have any collections? \_\_\_\_\_ If so, what do you collect?

Verbal Report:

**Appendix C**  
**Point Incentive Charts**

NAME \_\_\_\_\_

**WEEKLY OBSERVATION SHEET**

DATES \_\_\_\_\_

	M	T	W	Th	F	S	Su
(Mrs./Ms.) NONCOMPLIANCE:							
(Mrs./Ms.) COMPLIANCE:							
(Mr.) NONCOMPLIANCE:							
(Mr.) COMPLIANCE							

Target & Actual Time Of Observations	Target time for Mrs./Ms.	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End
	Target time for Mr.  From To	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End	C = NC = Start End

NAME \_\_\_\_\_

# INITIAL POINT INCENTIVE CHART

DATES \_\_\_\_\_ to \_\_\_\_\_

Behavior/Chores	Description	Value	M	T	W	Th	F	S	Su
Compliance	_____ _____ _____ _____ _____	1							
Chore #1	_____ _____ _____ _____ _____								
Chore #2	_____ _____ _____ _____ _____								
		Must Make	Total	Total	Total	Total	Total	Total	Total
		Identify Reward Chosen							

REWARDS (SELECT ONE)

*[Remember that the list should contain both social and tangible rewards]*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

NAME \_\_\_\_\_

# POINT INCENTIVE CHART

DATES \_\_\_\_\_ to \_\_\_\_\_

Behavior/Chores	Description	Value	M	T	W	Th	F	S	Su
Compliance	_____ _____ _____ _____ _____	1							
Chore #1	_____ _____ _____ _____ _____								
Chore #2	_____ _____ _____ _____ _____								
		Must Make	Total	Total	Total	Total	Total	Total	Total
		Identify Reward Chosen							

REWARDS (SELECT ONE)

*[Remember that the list should contain both social and tangible rewards]*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

<u>BACK-UP PUNISHERS</u>		TIME-OUTS							
1.									
2.									
3.		BACK-UPS							

## Appendix D

### Knowledge Checks

**KNOWLEDGE CHECK****Quiz One**

1. So, when you are home this week, how long are you going to wait after making a request before you decide if it was a compliance or noncompliance?

---

2. What if your child complies with your request but argues with you? What would you record?

---

3. What if your child does the task but waits for 25 seconds before he/she begins?

---

4. Where are you going to record your child's responses to your requests?

---

5. Consider the time periods you are going to be monitoring for the Weekly Observation Sheet. How long will you try to monitor?

---

6. What if you asked your child to turn off the t.v. and he/she did so immediately, but mumbled bad things under his/her breath? What would you record?

---

7. What if your child turns off the t.v. within 15 seconds and then opens up a book?

---

8. What if your child snapped back, "But it's not my turn!" and didn't budge?

---

9. What if your child turns off the t.v. but stomps his/her feet on the ground while doing it? What would you call his/her response?

---

10. What time periods are you going to monitor?

---



**KNOWLEDGE CHECK****Quiz Two**

1. Show me where you record the child's total for each day.

---

2. When you first explain the chores for the child, who actually does the chore?

---

3. Is it o.k. to steer the child away from any of the listed rewards?

---

4. Imagine a day where your child gets all their chore points and is good enough for most of the day to make his/her point total. However, he/she disobeys you right after supper. When you review the day with him/her before bedtime, does he/she still get his/her reward for the day?

---

5. If you ask your child to clean up his/her toys and he/she begin the task within 15 seconds but doesn't finish it before then, do you still assign a point for a compliance?

---

6. If your child complies with your request, what do you do?

---

7. How many points does your child need to get to meet the daily point total?

---

8. When you are reviewing your child's daily point total, which would be correct to say?.....

" I am very upset that you didn't meet your point total. You have disappointed me once again. You'd better work harder tomorrow, or else!"

OR..

" Well, you didn't get your points today, but maybe tomorrow you will. Tomorrow's a brand new day! If you get XX points, then you can choose from all those good rewards! "

---

9. If your child successfully completes all steps of both assigned chores, how many points would be earned?

---

10. How many warnings do you give your child before checking on a chore?

---

**KNOWLEDGE CHECK****Quiz Three**

1. What important piece of equipment must you have before you begin to use time-out?  
\_\_\_\_\_
2. Let's say that you make a request of your child and he/she is noncompliant. You should send them to what?  
\_\_\_\_\_
3. Say that they then walk in the bathroom and quietly close the door as expected. How long do you set the timer?  
\_\_\_\_\_
4. Let's say you've given your child a time-out but he/she continues to misbehave. What is the only thing that you can say?  
\_\_\_\_\_
5. What's the longest time you can send your child to time-out?  
\_\_\_\_\_
6. If you get to ten minutes for a time-out, what warning do you give your child after you say, "That's ten minutes." ?  
\_\_\_\_\_
7. If your child continues to be noncompliant with time-out, what do you say at this point?  
\_\_\_\_\_
8. Let's say that you ask your child to wash his/her hands and he/she says, "I don't want to." You tell him/her that's a time-out and he/she says, "I don't care." What do you say?  
\_\_\_\_\_
9. Then he/she stomps his/her foot and says " You can't make me." What do you say?  
\_\_\_\_\_
10. What if he/she gets up to 10 minutes - what do you say?  
\_\_\_\_\_

### KNOWLEDGE CHECK

#### Quiz One

1. So, when you are home this week, how long are you going to wait after making a request before you decide if it was a compliance or noncompliance?

The correct amount of time to wait is 15 seconds.

2. What if your child complies with your request but argues with you? What would you record?

This would be a Noncompliance because it does not meet our definition of compliance.

3. What if your child does the task but waits for 25 seconds before he/she begins?

This would be a Noncompliance because it does not meet our definition of compliance.

4. Where are you going to record your child's responses to your requests?

Either directly on the Weekly Observation Sheet or on a note card (note: parents will still need to transfer their observations to the Weekly Observation Sheet at a later time).

5. Consider the time periods you are going to be monitoring. How long will you try to monitor?

Each parent should plan to monitor for about one hour.

6. What if you asked your child to turn off the t.v. and he/she did so immediately, but mumbled bad things under his/her breath? What would you record?

This would be a Noncompliance because mumbling is a form of backtalk.

7. What if your child turns off the t.v. within 15 seconds and then opens up a book?

This would be a Compliance because it meets our definition of compliance.

8. What if your child snapped back "But it's not my turn!" and didn't budge?

This would be a Noncompliance because it does not meet our definition of compliance.

9. What if your child turns off the t.v. but stomps his/her feet on the ground while doing it?

Stomping is a form of arguing or backtalk, so this would be a Noncompliance.

10. What time periods are you going to monitor?

This is the one hour period that each parent agreed to monitor. It is recorded on the Weekly Observation Sheet.

Compliance is your child beginning to respond to your request within 15 seconds, with no back talk, arguing or whining.

Noncompliance is anything else.

Good luck! Be sure to call your therapist with any questions that come up.

### KNOWLEDGE CHECK

#### Quiz Two

1. Show me where you record the child's total for each day.  
On the **Point Incentive Chart** in the box marked **Total**.
2. When you first explain the chores for the child, who actually does the chore?  
You will actually do the chore when explaining the point system to your child.
3. Is it o.k. to steer the child away from any of the listed rewards?  
No. You must always be able to give your child whichever reward to choose for the day. So, make sure that they are reasonable and guaranteeable before they are put on the list!
4. Imagine a day where your child gets all their chore points and is good enough for most of the day to make his/her point total. However, he/she disobeys you right after supper. When you review the day with him/her before bedtime, does he/she still get his/her reward for the day?  
Yes. If your child earns their points, your contract is that he/she gets the chosen reward.  
(After next week, you will have a specific response for when your child doesn't mind you, so please be patient until then! )
5. If you ask your child to clean up their toys and they begin the task within 15 seconds, but don't finish it before then, do they still get their points for compliance?  
Yes, the child only has to start the task within 15 seconds, they don't have to complete the task within 15 seconds.
6. If your child complies with your request what do you do?  
Give them a point.
7. How many points does your child need to get to meet their daily point total?  
This amount was agreed upon earlier in the session, and should be recorded on the **Point Incentive Chart**.
8. When you are reviewing your child's daily point total, which would be correct to say?.....  
"I am very upset that you didn't meet your point total. You have disappointed me once again. You'd better work harder tomorrow, or else!"  
OR..  
"Well, you didn't get your points today, but maybe tomorrow you will. Tomorrow's a brand new day! If you get XX points, then you can choose from all those good rewards! "  
*The second response is the correct one.*
9. If your child successfully completes all steps of both of their chores, how many points will they get?  
This amount was agreed upon earlier in the session, and should be recorded on the **Point Incentive Chart**.
10. How many warnings do you give your child before checking on their chore?  
You may give only one warning to your child before checking on their chore.

### KNOWLEDGE CHECK

#### Quiz Three

1. What important piece of equipment must you have before you begin to use time-out?  
You must have a timer.
2. Let's say that you make a request of your child and he/she is noncompliant. You should send them to what?  
You should send them to time-out.
3. Then they walk in the bathroom and quietly close the door as expected. How long do you set the timer?  
The minimum time for time-out is five minutes.
4. Let's say you've given your child a time-out but he/she continues to misbehave. What is the only thing that you can say?  
You should say, "That's one more minute" or "That's another minute- that makes a total of 6 minutes."
5. What's the longest time you can send your child to time-out?  
The maximum amount of time-out is 10 minutes.
6. If you get to ten minutes for a time-out, what warning do you give your child after you say, "That's ten minutes." ?  
You should say, "If you don't go to time-out now, you will lose X (the backup punisher)."
7. If your child continues to be noncompliant with time-out, what do you say at this point?  
"O.k., forget time-out, no X (the backup punisher) for the rest of the day."
8. Let's say that you ask your child to wash his/her hands and he/she says, "I don't want to." You tell him/her that's a time-out and he/she says, "I don't care." What do you say?  
The only correct response is, "That's another minute," or "That's another minute. That's a total of X minutes."
9. Then he/she stomps his/her foot and says " You can't make me." What do you say?  
You would again say, "That's another minute."
10. What if he/she gets up to 10 minutes - what do you say?  
The only correct response is, "That's ten minutes. If you don't go to time-out now, you will lose X (the backup punisher)."

**Appendix E**  
**Parent Evaluation of Treatment**

**PARENT EVALUATION**  
**OF THE**  
**PARENTING STRATEGIES TRAINING PROGRAM**

**Directions:** We would like your feedback regarding the parent strategies program you attended. Please feel free to offer additional comments on the back of the sheet. Thank you for your assistance.

1. Were you satisfied or unsatisfied with the amount of time that elapsed between your first phone contact and the scheduling of your first appointment?

(1)	(2)	(3)	(4)	(5)
extremely satisfied	somewhat satisfied	neutral	somewhat <u>unsatisfied</u>	extremely <u>unsatisfied</u>

2. Were you unsatisfied or satisfied with your therapist?

(1)	(2)	(3)	(4)	(5)
extremely <u>unsatisfied</u>	somewhat <u>unsatisfied</u>	neutral	somewhat satisfied	extremely satisfied

3. How satisfied or unsatisfied were you with how the home observation component of the training was handled?

(1)	(2)	(3)	(4)	(5)
extremely satisfied	somewhat satisfied	neutral	somewhat <u>unsatisfied</u>	extremely <u>unsatisfied</u>

4. How useful were the quizzes given during the parent training sessions?

(1)	(2)	(3)	(4)	(5)
extremely useful	somewhat useful	neutral	somewhat <u>unhelpful</u>	extremely <u>unhelpful</u>

5. Has the training program helped or hindered you in your parenting?

(1)	(2)	(3)	(4)	(5)
significantly hindered my parenting	somewhat hindered my parenting	neutral	somewhat helped my parenting	significantly helped my parenting

6. Were you satisfied or unsatisfied with the overall amount of time required for parent training?

(1)	(2)	(3)	(4)	(5)
extremely satisfied	somewhat satisfied	neutral	somewhat <u>unsatisfied</u>	extremely <u>unsatisfied</u>

7. Overall, has there been any change in the amount of time spent in *negative* interactions (i.e., scolding, arguing, repeating requests, disciplining, etc.) with your child at home?

(1)	(2)	(3)	(4)	(5)
significantly increased negative time	some increase in negative time	no change	somewhat decreased negative time	significantly decreased negative time

8. Overall, has there been any change in the amount of time spent in *positive* interactions (i.e., playing, talking, working together, etc.) with your child at home?

- |  |  |  |   |  |
|--|--|--|---|--|
| (1)<br>significantly<br>increased positive<br>time | (2)<br>some increase in<br>positive time | (3)<br>no change in the<br>amount of positive<br>time spent with my<br>child | (4)<br>somewhat<br>decreased positive<br>time | (5)<br>significantly<br>decreased positive<br>time |
|--|--|--|---|--|

9. Are you unsatisfied or satisfied with the amount of change that you have seen in your child?

- |  |                                       |                |                           |                            |
|--|---------------------------------------|----------------|---------------------------|----------------------------|
| (1)<br>extremely<br><u>unsatisfied</u> | (2)<br>somewhat<br><u>unsatisfied</u> | (3)<br>neutral | (4)<br>somewhat satisfied | (5)<br>extremely satisfied |
|--|---------------------------------------|----------------|---------------------------|----------------------------|

10. Would you recommend this parenting strategies program to other parents?

- |                   |                 |                 |                     |                       |
|-------------------|-----------------|-----------------|---------------------|-----------------------|
| (1)<br>Definitely | (2)<br>Probably | (3)<br>Not sure | (4)<br>Probably not | (5)<br>Definitely not |
|-------------------|-----------------|-----------------|---------------------|-----------------------|

11. How do you rate your overall experience with the parenting strategies program?

- |                            |                           |                |                                       |  |
|----------------------------|---------------------------|----------------|---------------------------------------|--|
| (1)<br>extremely satisfied | (2)<br>somewhat satisfied | (3)<br>neutral | (4)<br>somewhat<br><u>unsatisfied</u> | (5)<br>extremely<br><u>unsatisfied</u> |
|----------------------------|---------------------------|----------------|---------------------------------------|--|



## **Appendix F**

### **Parent Consent Form - Control Group**



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## WESTERN MICHIGAN UNIVERSITY

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Principal Investigator: Kevin J. Armstrong, Ph.D.  
Doctoral Student Investigator: Maria Channell, M.A.

Dear Parent(s):

The Psychology Department at Western Michigan University is conducting several studies in the area of parent training. We would like your permission to use data generated from your participation in the program in our evaluation research. Data from individual cases will not be released unless specifically requested by parents to do so (e.g., sharing results with the child's school or pediatrician). If we publish the results or share the results at a professional meeting, no names or identifying information will be used.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

## **Appendix G**

### **Parent Consent Form - Experimental Group**

Principal Investigator: Kevin J. Armstrong, Ph.D.  
Doctoral Student Investigator: Maria Channell, M.A.  
Master Thesis Investigator: Ann M. McGrath

Dear Parent(s):

Your therapist has recommended that your child's treatment include training in parenting strategies from our clinic. We are asking that you consider agreeing to receive an add-on component to the parent training package that you are already scheduled to receive. This component is experimental. Specifically, we are asking permission for both you and your child to complete a form called the Children's Reinforcement Survey Schedule as part of an ongoing dissertation research project. This task will add approximately 15-20 additional minutes to your third session and will also require you to bring your child to that session so that he, too, may complete a form. The goal of this additional component is to improve the effectiveness of the parent training program. This component has been used successfully with other kinds of behaviour problems and treatment approaches but has not been systematically evaluated with ADD/ADHD children. Thus, we cannot be certain it will be helpful to you and your child.

There are no unusual risks to parents and children for completing this questionnaire. Both you and your child will be working with staff from the Clinical Psychology Doctoral Training Program. All training will be supervised by a doctoral level clinical psychologist and will be conducted by qualified doctoral students. Participation by both you and your child is completely voluntary and may be terminated at any time without prejudice or penalty to either yourself or your child. You may still receive the regular parent training program if you choose not to help evaluate the new component.

All information collected throughout the parent training program will be kept strictly confidential in a locked file drawer at Western Michigan University. No data from any individual case will be released unless specifically requested by the parents to do so (e.g., sharing results with the child's school or pediatrician). If we publish the results or share the results at a professional meeting, no names or identifying information will be used. Our master research file matching names and id numbers will be destroyed after final data analyses to further ensure confidentiality of your information. However, your clinical file will be kept in accordance with standard clinical practice so that case information will be available if you need it later. Additionally, we would like to send training assistants to your home on three separate occasions for about an hour in order to observe how your child acts within his family. Visits will be arranged at times which are selected by the parent(s) in collaboration with the primary therapist. These data will help us evaluate how well the intervention is working for your family. Training assistants are required to audiotape their home visits for clinical supervision purposes.

If you have any questions please call Dr. Armstrong at 387-8311. The participants may also contact the Chair, Human Subjects Institutional Review Board at 387-8293 or the Vice President for Research at 387-8298 if questions or problems arise during the course of study.

**PLEASE COMPLETE THE NEXT PAGE IF YOU WISH TO PARTICIPATE.**

PLEASE READ EACH STATEMENT AND CHECK YES IF YOU AGREE TO THE ITEM. IF YOU CHECK NO TO ANY STATEMENT, DATA FROM YOUR CHILD'S TREATMENT WILL NOT BE INCLUDED IN THE TREATMENT EVALUATION PROJECT.

1. I/we understand that I/we and my/our child have been asked to participate in an evaluation project designed to improve the effectiveness of a parent training program. YES \_\_\_ NO \_\_\_

2. I/we understand that both the parent(s) and the child will be asked to complete an additional paper and pencil questionnaire. YES \_\_\_ NO \_\_\_

3. I/we understand that I/we or my/our child may experience some mild distress from completing the questionnaire. If such distress were to occur, appropriate therapeutic support or a referral to another clinic would be offered. YES \_\_\_ NO \_\_\_

6. I/we understand that Dr. Armstrong will answer any questions I/we have about participating in this evaluation study if I/we call 387-4472 YES \_\_\_ NO \_\_\_

7. I/we understand that all information collected will be kept strictly confidential. YES \_\_\_ NO \_\_\_

8. I/we voluntarily give permission for me/us and \_\_\_\_\_  
(name of child)  
to participate in this program. YES \_\_\_ NO \_\_\_

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to the subject except as otherwise stated in this consent form.

Signature of Parent(s) \_\_\_\_\_

Date \_\_\_\_\_

If you would like to be called concerning questions you may have about this study, please give us your home and/or work number and a good time when you can be reached.

Home \_\_\_\_\_ Best Times \_\_\_\_\_

Work \_\_\_\_\_ Best Times \_\_\_\_\_

**Appendix H**  
**Child Assent Form**

## TO BE READ WITH CHILD

We are working with your parents here in our clinic to help you do even better at home and school. We would like you to participate in an experiment. First, we want to explain what you would have to do and then answer any questions you have. If you want to help in the experiment, we will start today. If you decide you'd rather not do this, that would be o.k., too.

If you help in the experiment, we will ask you to answer questions about what you like and dislike, and what types of things you like to do.

We will ask you to come here with your parents on one more day sometime during the next 3 months so you can answer the questions.

Remember, you don't have to come and there will be no penalty or problem if either you or your parents don't want to do this.

Do you have any questions?

If you agree to help with this, please sign below.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Appendix I**  
**Medication Status Sheet**



1. My child has been diagnosed Attention-Deficit/Hyperactivity Disorder (ADHD, ADD, Hyperactive). YES \_\_\_\_\_ NO \_\_\_\_\_
  - a. If yes, when was the diagnosis made? \_\_\_\_\_
  - b. If yes, who made the diagnosis? \_\_\_\_\_
2. Has your child received any additional medical or psychiatric diagnoses; other than Attention-Deficit Hyperactivity Disorder? YES \_\_\_\_\_ NO \_\_\_\_\_
  - a. What is the name(s) of the diagnosis? \_\_\_\_\_
  - b. If yes, when was the diagnosis made? \_\_\_\_\_
  - c. If yes, who made the diagnosis? \_\_\_\_\_
3. Is your child currently taking any prescribed medication? YES \_\_\_\_\_ NO \_\_\_\_\_
  - a. If yes, what medication is your child taking? \_\_\_\_\_
  - b. When did your child start taking the medication? \_\_\_\_\_
4. Has your child been on any additional prescribed medication to that described above? YES \_\_\_\_\_ NO \_\_\_\_\_
  - a. If yes, what medication was your child taking? \_\_\_\_\_
  - b. When did your child start taking the medication? \_\_\_\_\_
  - c. When did your child stop taking the medication? \_\_\_\_\_

---

(For office use only)

Id # \_\_\_\_\_

**Appendix J**  
**Parenting Strategies Manual**

### **Parenting Strategies Training Manual**

***Important: Do not attempt to implement this intervention until you have been trained.***

#### **CONTENTS**

**Introduction and Overview**

**Treatment Session 1: TRACKING PROCEDURES**

**Treatment Session 2: POSITIVE POINT PROGRAM**

**Treatment Session 3: TIME-OUT PROGRAM**

**Treatment Sessions 4 to 6: FOLLOW-UP ISSUES**

## INTRODUCTION & OVERVIEW

This manual has been developed for a number of studies examining the utility of a parent training intervention for families with children who have been diagnosed with Attention Deficit Hyperactivity Disorder. The manual is intended to facilitate the standardized delivery of a Patterson-based treatment program. It is recognized that it is difficult or even impossible to standardize all aspects of treatment delivery. One cannot predict or control all of the complex interactions which occur between therapists and clients (e.g., creating a positive expectancy, dealing with objections and concerns, or negotiating a motivating reframe of the referral problem). Instead, this manual provides specific directions to therapists for provision of essential content of the intervention and offers general directions for common process issues.

### Content

The intervention is composed of three major sets of skills based on social learning theory. These skills must be taught and demonstrated in the fixed order presented. The first intervention week is spent practicing observation techniques at home. The second session focuses on implementation of the Positive Point Program which provides daily rewards for targeted levels of compliance with parental requests and for independent completion of new chores. The third session focuses on how to correctly use time-out procedures for noncompliance. The final sessions are for helping parents develop general problem solving skills to deal with other issues (e.g., using the program's strategies to deal with new or persistent behavior problems, how to conduct time-out away from home, modifying the program as the child ages, extending the program to other children at home, etc.). Therapists will find that the manual is very specific about the content of each session until session #4. At this point, the therapist will have topics to offer the parents but the content of the final sessions will be determined by the parents' remaining concerns.

A programmed teaching approach is utilized throughout the first 3 sessions. Material is presented didactically and then parents are given training scenarios to facilitate acquisition and application of key concepts. When this is completed, final quizzes are used to help the therapist identify if the parents have mastered critical information. In this way, deficiencies are quickly identified and the therapist can offer remediation upon completion of the quizzes.

There are a number of philosophical issues which shape the content of this treatment. Consider several questions.

1) *Why not just teach punishment? That's what most parents want!* The use of the Positive Point Program is essential for most of these families because many parents have not been taught the power of shaping and other positive reinforcement strategies. Many parents are skeptical of the power of positive parenting techniques because they believe that their own parents used them sparingly. One risk, therefore, is that parents will rely too much on the time-out component. Therapists must be vigilant regarding this possibility. The rationale to offer parents is that children need to be taught about what they should be doing, not just what they shouldn't be doing.

2) *Who should establish standards and expectations for the child?* Unless it creates or maintains a dangerous environment for a child, therapists should respect the parents' authority in deciding standards and expectations for their children. Parents know what values they want to instill in their children and we want to offer them a set of strategies which will enable them to be the best teachers they can be. This set of strategies relies on the parents making appropriate use of requests and consequences in teaching their children habits and rules intended to make them happier and more productive. The parents decide which requests to make and identify both appropriate rewards and expectations. The punishment approach relies on time-out because researchers suggest that families with children who are noncompliant have extremely high levels of reciprocally aversive interactions - especially at times where problem behavior occurs.

3) *Can we expect generalization of treatment effects?* Teaching children compliance with parental requests often helps them get along better with a variety of adults and other children. However, programming for generalization of treatment effects remains an important challenge for therapists. For example, the most desired form of generalization for home-based treatment of ADHD children is usually to the classroom. Due to time and resource constraints, it is impractical for teachers or other school

officials to carry out a parallel version of this program in a large classroom. However, establishing positive and useful communication between teachers and parents is essential. A separate program has been developed to assist with classroom behavior concerns but it will not be discussed in this version of the manual.

### Process

There are several relevant process issues related to conducting this kind of intervention. Before attempting this kind of treatment, therapists should consider the impact of their own behavior on clients. Patterson and his colleagues at the Oregon Social Learning Center noted that skills-based parent training programs are met with increased noncompliance by parents when therapists engage in excessive teaching and confrontation. Instead, parent compliance is positively associated with increases in supportive and facilitative statements made by the therapist. Patterson suggests that three therapist skills are vital to increasing client cooperation levels. First, therapists must have skills for joining with or engaging the client in the therapy process. Second, therapists must be able to supportively reframe the problems or obstacles generated by parents. Third, therapists must be persistent when confronting and teaching parents.

Joining with and Engaging the Client. Therapists need to listen to and then empathically restate their client's words when the parents are asked to describe their child's difficulties and the negative impact of their child's behaviors on the child and family. Be aware of the personal motivations of the parents. Do they feel embarrassed of their child's behaviors at family gatherings? Do they anticipate difficult parent-teacher conferences? Are they worried they have been poor parents? Do they feel scared that their child won't succeed or will be rejected by other children? Do they want to reduce fighting or other forms of aggression at home or do they want to help their child to complete work independently? Were the parents self-referred or were they referred by another professional or the court system? Once you know why the parents are seeking help, you can offer more specific forms of encouragement. If it is ethical to do so, remind them that successful completion of the parent training program will likely bring them and/or their child a specific type of relief. Data suggest that while you can't guarantee a positive outcome to the parents, you can report that a majority of parents who complete this intervention see significant improvements in the children's behavior.

Reframing Problems and Obstacles. During any kind of therapy, clients will present with problems or obstacles to establishing or following the treatment plan. The problems are sometimes predictable and easily handled. Other times the problems are surprising and seriously diminish the chances for successful completion of therapy.

Therapists should keep in mind two things about their *clients* at all times. First, what motivated the client to seek treatment in the first place? Second, what changes are ultimately desired by the client? Therapists must express to the parent(s) in every session that they understand these two things. Therapists should attempt to match their client's vocabulary in describing these factors.

Therapists should keep in mind two things about their *therapy* at all times. First, how does your intervention help meet the client's overall treatment goals? Second, what does it cost your client (e.g., time, money, pride, status in the extended family or local community) to do the things you ask? Be able to convincingly communicate the connection between the client's goals, the intervention, and the anticipated outcome of their efforts.

Common obstacles are varied. At the end of the manual, I have identified several of the more frequently discovered obstacles and provided possible responses for the therapist. It is essential that therapists have a broad and effective repertoire of responses for obstacles or objections which may occur.

Persistence in Teaching and Confronting. Therapists must strike a balance between being empathic and supportive while at the same time getting through the specific components of a skills-based package. Keeping the parents on task and completing the sessions on-time require that the therapist be persistent in teaching and confronting the parents. Parents have often been socialized to believe that therapy is a place for them to vent, share feelings, or seek support for their current behaviors and feelings.

In contrast, this skills-based package affords limited time for parents to provide lengthy descriptions of problems or personal reactions. Therapists are active and directive, rather than passive and reflective. The intervention emphasizes review of essential concepts and skills so that parents can actively change behavior at home each week. Considering these factors, therapists must be effective in acknowledging interruptions or uncooperative responses while maintaining control of the session. Here are some things that therapists can say:

THAT SOUNDS IMPORTANT AND I WANT TO HEAR MORE ABOUT IT. I'LL MAKE A NOTE TO MYSELF REMINDING ME TO ASK YOU ABOUT IT LATER, BUT IF WE ARE GOING TO STAY ON TRACK, WE HAD BETTER GET THROUGH TODAY'S AGENDA. IS THAT O.K.?

OR

THOSE ARE IMPORTANT GOALS/NEEDS FOR YOUR CHILD, TOO. IT MAKES SENSE THAT YOU BRING THEM UP. LET ME SUGGEST SOMETHING FOR RIGHT NOW. I'M THINKING THAT GETTING THROUGH THE COMPLIANCE TRAINING INTERVENTION WILL HELP SET YOUR CHILD UP FOR SUCCESS IN MEETING THESE OTHER GOALS/NEEDS LATER. REMEMBER THAT AFTER THE COMPLIANCE TRAINING PROGRAM IS IN PLACE, YOUR CHILD WILL BE A MUCH BETTER LISTENER AND WILL BE ABLE TO LEARN FROM YOU MUCH MORE QUICKLY THAN HE CAN NOW. IMAGINE TRYING TO HELP YOUR CHILD WHEN HE IS A BETTER LISTENER. THAT IS WHY WE SHOULD GET SOME GOOD HABITS IN PLACE NOW AND BOOKMARK ACTING ON THESE OTHER GOALS UNTIL WE HAVE A BETTER CHANCE TO QUICKLY HELP WITH THOSE THINGS. WOULD IT BE O.K. WITH YOU TO BOOKMARK DEALING WITH THESE OTHER ISSUES SO THAT WE CAN GET THIS IMPORTANT GROUNDWORK LAID?

IT LOOKS LIKE YOU WEREN'T ABLE TO COMPLETE YOUR HOMEWORK THIS WEEK. WHAT GOT IN THE WAY? [LISTEN] I KNOW IT'S A LOT OF WORK TO FILL OUT THESE SHEETS EVERYDAY BUT I HONESTLY BELIEVE THAT TAKING THIS TIME NOW, OVER THE NEXT 3-4 WEEKS, WILL SAVE YOU A TREMENDOUS AMOUNT OF TIME IN THE LONG RUN - TIME YOU MIGHT SPEND ARGUING WITH YOUR CHILDREN, NAGGING THEM, ASKING THEM TO DO THINGS A MILLION TIMES, DOING THINGS FOR THEM JUST SO YOU CAN AVOID HAVING TO CONFRONT YOUR CHILD OVER THEIR NOT DOING WHAT YOU ASK. WHAT CHANGES CAN YOU MAKE THIS WEEK SO THAT YOU CAN COMPLETE THESE CRUCIAL TASKS?

A programmed manual cannot anticipate all of the problematic situations which can develop in treatment sessions. Conducting therapy is challenging. It is up to the therapist to master and provide the intervention to one or more lively, independently thinking, differently motivated, and differently abled parents.

#### A Final Note

Therapists who utilize parent training components in their interventions have special rewards. First, therapists gain the confidence that comes from using adaptable, empirically based interventions. Second, they are providing an intervention which can help children 24 hours a day, 7 days a week. This is a significant advantage over seeing a child in your office for 50 minutes, once a week. Third, therapists get to be part of substantial and positive changes families' lives. I hope that you find conducting family interventions to be as humbling and as inspiring as I do. Good luck!

K.J.A.

## Session 1: TRACKING PROCEDURES

### I. Introduction

	[Get a brief description of why the parents are seeking treatment now. Listen, but conclude with] "It sounds like a good idea for us to review some parenting strategies that may assist you in helping your child to decrease some of those problem behaviors and increase some of the behaviors you would like to see more of. Let me describe what we are recommending for you."
	Our topic each week is changing behavior and there are 3 basic skills involved: Week #1 has to do with seeing behavior and tracking it. You must monitor and focus on the most important parts of your child's behavior. This is a prerequisite to providing consistent feedback. It's important for us to develop a way to talk to each other about your child's behavior so that we know exactly what each other is talking about. More on this later today.
	In Week #2, after identifying problem behaviors, we can take their opposite, prosocial behaviors and reward them. By rewarding positive behaviors that are incompatible w/ negative behaviors, we can reduce problem behaviors and increase those behaviors you'd like to see more often. For example, if one of the problem behaviors is fighting with a brother or sister, we can reward the child for cooperative play. We'll talk more about these strategies next week.
	Finally, we will work out a non-physical, no hassle way to effectively punish behaviors you don't want to see in your child. This will involve a very special form of "time-out" that is far more effective than the most commonly used variations of time-out. Many parents feel they have tried this before but the fact is that most parents have not ever been shown the most effective way to use time-out procedures to punish inappropriate behaviors. Notice that we will not be going over the time-out program until after we have hooked your child on the reward program and taught him or her more appropriate and positive ways of responding. This is important because we should never use punishment unless the child is both capable of and knows how to act more appropriately.
	The program we'll be teaching you is unusual in that it's an example of therapy which follows research - not vice-versa. About 10 years of research preceded development of this program. Outcome research predicts that this program is effective for 8/10 families - we'll know if it is going to work for your family within about 4 weeks. Ready to get started?

### II. Defining Compliance and Noncompliance

	When you are with your child, there are a lot of requests you make - stop or start, usually. Examples are:  <div style="display: flex; justify-content: space-between;"> <div> <u>Stop</u>  Stop jumping on the bed.  Turn the television off.  Quit hitting your sister. </div> <div> <u>Start</u>  Come to table.  Start working on your homework now.  Bring the dog into the house. </div> </div>
	What are some requests you make? [Identify them as start or stop requests]
	After you make a request, your child can do any number of things. Patterson, the leading figure in this research based therapy program, has found that there are 2 behaviors that encompass all others. When you make a request of children (again, to start or stop something), they either do it or they don't. But let's get into the details of what makes your child's response acceptable or unacceptable.
	Compliance is, of course, doing what you ask and non-compliance is not doing it. But let's define them using the "stranger rule." If a stranger were to walk into your house and watch your child, how would the stranger know if the child's response is compliance or noncompliance? We have to agree on a few things about how we will define this. Say this stranger was observing in your house about 6pm. A parent comes into the tv room and tells the children, "Time to wash your hands and come to the table." In some families, the children are supposed to come right away while in others, the children can wait for the show to be over or for a commercial to come on. A

	stranger might have a hard time telling if a child were complying with the parents' requests unless they knew how long the child had to meet the request. So, common sense says: doing what they are told is part of the definition. But how immediately should the child comply with your request (excluding safety issues like put the knife down or get out of the street...)? Here's a hint: it should be long enough to complete their current task (or at least get to a stopping point), but not so long that a billion other things happen.
	[Allow parent(s) to talk to each other about specific time periods.] Now, keep in mind that this time span is for <u>routine requests</u> and not for <u>emergency requests</u> or for <u>time-linked requests</u> . Emergency requests include "Get your hand away from the stove," "Put that down now," and "Don't eat that!" Time-linked requests include "You can do it when the show is over" or "Make sure you finish it before you leave for school," "Get your bath in before 6:00 tonight," or "After we finish dinner, I want you to start on it." We recommend that parents not rely on time-linked requests with children who don't have good compliance habits yet. It's simply too easy for them to forget what the original request was! So how long should you wait for a routine request?
	[Respond to parent suggestions by pointing out that there are advantages to giving longer periods of times (which allows the parents time to go do something else before coming back to check to see if the child has done it) and to giving shorter periods of time (which decrease the chance of other things capturing your child's interest and causing them to forget the request). However, research suggests allowing 15 seconds for the child to initiate compliance with a request.]
	[If parents feel 15" is too short a time period, get a timer out and demonstrate by having them ask you to pick up a pencil. Call out times at 15", 30" on up to whatever time they felt was good. If necessary, point out that if the request doesn't need to be done that quickly, parents should save the request for later or make a time-linked request.]
	Now, would back-talk or arguing be o.k.? [Whatever parents say, discuss the following issue.] Research suggests that kids who back-talk or argue with teachers are more at risk for being labeled as "trouble-makers" or "problem children." Back-talk and arguing undermine a teacher's authority in a classroom and make it difficult for everybody to learn effectively. Arguers and Back-talkers also end up learning to argue and back-talk in order to escape or avoid difficult tasks. It may be appropriate for a child to ask nicely why something needs to be done but it is not appropriate for children to use these questions as delay tactics or as challenges to a teacher or even a parent's authority.]
	Would whining be o.k.? [Research suggests that kids who whine are less popular with classmates and that whiners are often avoided by teachers who usually choose ignoring strategies to help minimize the whining. It's alright for a child to feel sad or angry about having to quit doing something they enjoy but it's not alright for the child to use whining as an escape or avoidant tactic. Some kids even learn to whine so much that they can get other people to do things for them just to stop the whining. We think it's best that kids not learn to express their sadness or anger through whining.]
	[Get agreement here before going on.]
	O.k., our stranger rule definition for compliance will be this: "doing what he's told within 15" without back-talk, arguing, or whining."

### III. Examples

	TRAINING SCENARIO	PARENT'S RESPONSE (circle one)
	Let's try some examples. Let's say that you ask your child to hang up their coat. Your child says "[use whining voice] Aw, mom, I don't want to - there's a good show on." Is this a compliance or a noncompliance? (It's a noncompliance because of the whining and because we didn't say anything about your child doing it.)	Compliance or Noncompliance



	Let's say your child does it, but takes 20 seconds before going over to where the coat is. (This is a noncompliance because it took more than 15 seconds for him to begin complying with your request)	Compliance or Noncompliance
	<b>TESTING SCENARIO</b> OK, now we want to see how well you understand this. Let's keep with the example of you asking your child to turn off the tv. Consider each of the situations and tell me if it is a compliance or noncompliance. I'll tell if you are right or wrong when we are done with all four examples. [Get all answers before giving feedback.]	
	Let's say you ask your child to turn off the tv. He watches for another 10" but then turns it off. Is this a compliance or a noncompliance? (This is a compliance because it is a nonemergency request).	Compliance or Noncompliance
	What if your child turned the tv off. immediately but mumbled bad things under his breath? (This would be a form of backtalk so its a noncompliance)	Compliance or Noncompliance
	What if your child turns the tv off within 15 seconds and then opens up the newspaper? (This is a compliance.)	Compliance or Noncompliance
	What if your child snapped back "But it's not my turn!" and didn't budge? (This is a noncompliance - he didn't do what you asked.)	Compliance or Noncompliance
	What if your child turns the tv off but stomps his feet on the ground while doing it? (This is also a form of backtalk that would make it a noncompliance.)	Compliance or Noncompliance
	[Now provide feedback and discuss further examples, if needed]	
	Note that if you have to ask your child 5 times to take the garbage out and he ignores you each time, that is 5 separate noncompliances!	
	Any questions?	

#### IV. Completing the Weekly Observation Sheet

	Who will play secretary today? [Give Weekly Observation Sheet to parent.]
	The first thing for you to do is write down the definition for "compliance" in this box [point]. I'd like to suggest that you leave off the reference to within 15" because eventually your child will see this paper and may decide that they always have 14 seconds before they need to respond. Think about the child who only starts to act if the parent begins counting and gets to two and a half! We don't want your child to think that your requests are optional or that the requests can be met when it's convenient for the child UNLESS you specifically tell them they can do it anytime.
	Next, see that "noncompliances" would be marked here [point]. No need to write out its definition because your child's response will be either a compliance or it won't be.
	If it's a compliance, it would be marked down here. If it's anything else, it's a noncompliance and would be marked here.
	Is there any other problem behavior you want to monitor? [Most parents will say no. However, some parents want to keep track of things like the number of tantrums, number of fights with a sibling, or number of nights where bed-time was a hassle. Work with parents to operationalize their concern in a way that can be reliably observed. Have the parent write it down on the form underneath the box for (Mr.) COMPLIANCE. Usually, parents select a behavior they want to monitor all day so you don't have to restrict them to monitoring for just one hour. Note: parents who have a suggestion may be concerned that an intervention which simply targets compliance/noncompliance may not address their child's problems. You may need to explain that low frequency problem behaviors are often treated more effectively by building foundation behaviors like compliance - Compliance is an important habit. When kids don't develop habits of complying with adult requests the children are more vulnerable to developing other bad habits such as lying, stealing, or even fire-setting. Research is very clear that compliance is an extremely important habit for children to develop.]

	Now, you can tell from the sheet that there is room for you to monitor your child every day of the week. You and I both know that there is no way you could observe your child 24 hours a day. Instead, you should each observe 1 hour/day (not t.v. time, but when requests typically occur - e.g., before dinner, bed-time, when you get home from work, etc). It should be a time that is fairly regular so that you can start it within about 30 minutes each day, but it should also be when the same general set of requests occur - e.g., getting ready). When is good for each of you? [decide and write down the general times for Mr. and Mrs..]
	On the sheet, record the <u>actual</u> time you observe for because I will want to be able to calculate a rate per minute of these behaviors. This will help me decide how best to advise you about which strategies may be best for your child. Also, it will be important for you to see what kind of effect we are having as time goes on. Your observations will help you decide if your child is responding well to the strategies we agree on.
	Most parents prefer to carry a 3 x 5 card and pencil with them during their monitoring period. They find it easier than carrying the whole sheet. It is essential that you find a method that will work for you because research shows that if you don't record your child's responses immediately, you'll be left to rely on your memory later on and our memories are not very good with this kind of data. What will be easiest for you to do at each of your times? Do you think you will use 3 x 5 cards? Or can you leave the sheet in the same room you will be in at your designated time and just record things as they happen?
	In the meantime, do not change your response to the child's behavior - instead, do what you've been doing except wait 15" before recording a noncompliance or otherwise responding. Later, we will talk about different ways of responding. So, for right now, you 1. will make normal requests 2. wait 15" before repeating 3. will record immediately on the sheet or 3x5 card.
	Don't explain anything to your child yet - he/she may figure it out, and if he/she does, that's no problem. Ignore their questions, or simply say "You'll find out soon enough."
	You may discover that simply starting the tracking may lead to an increase in positive behaviors, but data suggest that these increases are typically only temporary. So, keep tracking until our next appointment.

#### V. Review

	So, as parents, you are to track/observe your child's behaviors and then do something immediately - this week it's record. You will make your request, wait 15", then record their response as a "N" or a "C."
	*This skill is prerequisite to beginning the next part of behavior changing! Next week: Assuming the tracking goes well, we'll cover how to increase positive behaviors.
	Any questions? Feel free to call us at 387-3965 if you have any questions. [Give additional sheets if the next appointment is more than a week away.]

VI. Say, "Here is your Final Quiz for today!" [Emphasize that parents should agree on one answer and that you will provide the right answers after you've asked all ten questions.]

	1. So, when you are home this week, how long are you going to wait after making a request before you decide if it was a compliance or noncompliance?	
	2. What if you child complies with your request but argues with you? What would you record?	
	3. What if your child does it but waits for 20 seconds before he/she begins?	
	4. Where are you going to record your child's responses to your requests?	
	5. Consider the time periods (each of) you are going to be monitoring. How long will you try to monitor?	

	6. What if you asked your child to turn off the t.v. and he/she did so immediately, but mumbled bad things under his breath? What would you record?	
	7. What if your child turns off the t.v. within 15 seconds and then opens a book?	
	8. What if your child snapped back "But it's not my turn!" and didn't budge?	
	9. What if your child turns off the t.v. but stomps his feet on the ground while doing it?	
	10. What time periods are (each of) you going to monitor?	

**Quiz One - Answer Key**

1. 15 seconds
2. Noncompliance
3. Noncompliance
4. On a note card
5. One hour
6. Noncompliance
7. Compliance
8. Noncompliance
9. Noncompliance
10. These times should have been agreed upon earlier in the session. The therapist is simply reinforcing the agreed upon time periods for the parents.

## Session 2: POSITIVE POINT PROGRAM

### Review & Introduction

	[Review tracking sheets: How did it go? Let me see the sheets.]
	TO DETERMINE IF YOU SHOULD GO AHEAD WITH THE PPP: [Reviewers: How is this for a decision making rule?] Parents must complete tracking on 5 of the 7 days.
	[IF IT WENT WELL] You are off to a good start. You have been practicing some important skills over the past week or so. You made requests, waited up to 15 seconds, and then got in the habit of immediately doing something. For this past week, what you did was record your child's response as a compliance or a noncompliance. What you do over the next couple of weeks will be a little different. Anyway, by doing a good job on the tracking phase, we have a pretty good idea about your child's compliance rates right now and I have a better idea about how your child is doing. Good job! We want you to keep completing the weekly observation sheets for the next 6-8 weeks. This helps us know if your child is having trouble at particular times of the day and also helps us evaluate the overall impact of these strategies in helping parents to help their children. [SKIP THE NEXT SECTION]
	[IF IT DIDN'T GO WELL] Well, we didn't get off to the right start. It sounds like it has been pretty hectic in your house over the past week or so. We can't get going on the intervention though until we have some agreement on what it is we are going to change. Let's use our time today to review your concerns or any obstacles that might exist. If we decide to pursue the parenting strategies program, we can take a little time to figure out how we can make this doable given your schedules and commitments. If this program isn't right for you, then we can discuss other options for helping you to help your child.
	We can go 1 of 2 ways here. Would you like to discuss how to get around some of the obstacles to getting started with the parenting strategies program or are there some other issues you wanted to bring up today?
	Discuss potential obstacles & possible solutions: a) lack of time or too tired b) disagreement between spouses about whether the child needs help or whether pursuing parenting strategies is the best way to do it c) marital conflict or one parent has a significant issue unrelated to children d) family emergencies or a number of special events occurring (vacation, surprise visit from in-laws, illness, work emergency)
	[Seek agreement about next plan of action - if some other issue is more important, agree to postpone the teaching of parent strategies and seek supervision as appropriate.]
	[If the parents agree to try tracking again, ask them when you can call in the next 48 hours to check on how things are going.]
	[- remind parents of how important this tracking is: you can't change something unless you both agree what it is (the "stranger rule") and whether or not it happened. Remind them that families who get through the tracking week usually do very well by the fourth week of the strategies program.]
	[Make sure the parents have fresh sheets and a phone number where they could contact you.]
	[IF IT WENT WELL, cont'd] Our topic this week is how to increase desirable behaviors - using the Positive Point Program. We'll be covering strategies for helping your child develop good habits. One good habit is doing what you ask them to do. Another good habit is completing a couple of household chores everyday without having to be reminded more than once.
	It's important to begin with this part of the program before we start using the punishment strategies. This helps children to learn better from requests and gets them seeing the good side of having you watch them closely.

	Often, increasing compliance at home leads to improvement in school behavior, but if not, we'll tackle it directly later.
	Now, one way to decrease negative behaviors is by increasing positive, prosocial, incompatible behaviors. Are you ready to get started?

### Selecting Target Behaviors to Increase

	[Get out green PPP sheet] Who will be secretary today?
	- First, write down the definition of compliance here [but leave out the 15" reference!]
	Next, we need to identify two chores that are doable and can be done on a daily basis. This is one strategy for teaching children to complete tasks independently. If we can help your children complete tasks independently, you won't have to feel like you need to watch them like a hawk just to make sure they get things done. Now, most parents choose tasks their child is already capable of doing but doesn't do on a regular basis. Common examples are: cleaning a bedroom cleaning up the bathroom after a shower feeding a pet or cleaning a cage clearing the table after a meal cleaning the yard [*NOTE: DON'T USE HOMEWORK HERE. SAY "WE CAN TALK ABOUT THAT IN A FEW WEEKS."]
	[Pick two chores and break them into 3-6 components each. Use the examples below. Be specific about standards for knowing if the the job is done at an acceptable level. Make sure the child is capable of doing the tasks. Ask: "If your child did these things, would the job be done to a reasonable standard?"]
	Example - Cleaning a bedroom (Hard to do if room is shared) 1. Toys in toy box (or closet). 2. Books on bookshelves. 3. Dirty clothes in hamper. 4. Clean clothes in drawers. 5. Pillow at one end of bed, blanket stretched out. [No need to bounce a quarter off it!]
	Example - Cleaning up bathroom after a shower 1. Shampoo cap screwed back on. 2. Soap in soap dish. 3. Towel and washcloth hung up. 4. Spills wiped up with x. 5. X placed in tub (or put in laundry).
	Example - Feeding a pet 1. Replace old water. 2. Provide x amount of food. 3. Clean up spills with paper towel. 4. Return food bag to closet and close door.
	Example - Clearing the table 1. Napkins thrown away. 2. Silverware & China placed on counter. 3. Milk/Soda returned to refrigerator.
	Example - Cleaning the yard 1. Return bikes to their wall. 2. Balls, gloves, skateboards, etc. to their shelf. 3. Garbage picked up and placed in trash can. 4. Close the garage door.
	Write down components in appropriate boxes.

### The Point System and Selecting Rewards

	We are creating a mechanism by which he can earn points toward rewards. Our goal is to have a way to reinforce a "work ethic." This is <u>not</u> bribery. Bribery is giving somebody something to do something they should not do. We are rewarding behaviors the child should be engaged in - just like bosses provide paychecks for work performed on the job. Our goal is to help the child internalize motivation for doing the chore, so that they eventually do it on their own.
	Now, let's review the types of rewards which can be used for helping your child.
	Now, let's think of some rewards: Some should be tangible, material things and others should be things the child can do with you (1/2 tangible, 1/2 social). - use stuff he doesn't ordinarily get and that you don't mind him getting! You might find it helpful to think of the things he wants from a dollar store or things that catch his eye in the grocery store checkout lane.
	Some of the rewards can be given everyday and some (maybe 1-2 things) are for 1-2x per wk.
	So, our job is to come up with stuff that is guaranteeable, can be given either every day or once or twice a week, and mixes tangible and social rewards. Let me give you some examples!
	1. Money: Keep in mind there are 2 reasons for giving children money. One is to help the child save money and the other is to give the child money they can spend immediately. We suggest that you provide money they can spend immediately, because you can teach saving another way that makes more sense to children. We'll tell you about that in a minute. [First, decide the maximum amount per week and maximum # of times per/wk (e.g., some use \$2.00 total, so that would be \$1 your child could pick up to 2x/wk, for a \$2/wk max)]
	2. Going to McDonalds/DQ/etc. (their choice) on the weekend or some day you can guarantee delivery (this reward could be chosen any day but only delivered when the parents can actually do it - this helps keep parents from promising something they can't do...). This could be chosen one time per week. This doesn't mean the whole family has to eat there, but it could if the place was liked by everyone.
	3. Grab bag of inexpensive stuff (can be chosen 1-2x per week). Tip: don't get such expensive stuff that you can't keep it up!
	4. Big object: This is how we prefer to teach savings - cut up a picture of some big or expensive item you want to buy for your child, create a grid maybe 3 x 4 pieces high and wide after deciding on # of pictures needed to get the object. The first time you do this, you may want to plan about 3-4 months ahead so that the child gets a desired object (skateboard or hockey equipment) at the appropriate season of the year. The child can pick a picture piece 1-2x/wk. Glue the piece to the grid and post it on a bedroom door or the refrigerator so the child can see the object take form over time. When the picture is filled in, you have to get it so be sure you are tucking the money away at the same time the child is picking the pieces!
	5. Rent a videotape or game cartridge: decide what kind up front (e.g., no Mortal Combat II), when (e.g., F, Sat, Sun), how many times per week, etc. Decide and announce restrictions ahead of time so that picking the reward remains a fun time rather than a time to argue and negotiate!
	6. Select a family activity: work on puzzle together, make popcorn, bake brownies, etc.
	7. 15 minutes free time with Mom. Be willing to play any games or help with a project that the child chooses!
	8. 15 minutes free time with Dad.
	As you look at your list, ask yourselves: Can you keep it away unless he has earned it?
	[Ask if the parents are considering these strategies for use with other children. If there are, please suggest that:] Well, first it's good to take a kid w/behavior problems who normally gets attention for negative stuff, and make him/her special in a positive way. After time-out next week, other children may not want any part of the program! Later, we can do the program w/others, but not yet.)

## II. How to get from Compliances to Rewards

	- child gets one point per compliance during the day.
	- child gets one point for each step of chore that is completed. So for chore number 1, the child can get 0-5 points, the same with chore #2. "Each successfully completed step is equal to one point."
	Let's decide on an easy total for the first week - a number he/she can easily get everyday. Let's get the child hooked into the program as quickly as possible. We like to start by using half of the points available from the two chores plus about 4 compliance points. So, if your chores have (5+3) steps, we would take half of that (4) and then add 4 so the target begins at 8. What would yours be? [Help the parent come up with a number. Do NOT allow them to make the number any higher. Stress that you know this number looks easy to make and that is exactly the point. We want the child to get into the program immediately - remind them that next week's strategy of "Time-out" will help make sure the child doesn't just quit at 3:00 in the afternoon if he or she has already met their point total. You can also tell them that we will be raising the point total after a couple of months.]
	Every time the child complies during the day, record the point on the chart. Similarly, everytime you check a chore, record their points on the chart. The chart should be in some public place - the refrigerator door may be best but many parents use the back of the child's bedroom door, a kitchen pantry or closet door, or whatever. Where will you try it in your house?
	Some parents prefer to carry their pen and 3 x 5 card for recording points throughout the day. They use the same card they are using for their one hour of daily tracking. Whatever you choose, make sure you get the points transferred over to the main sheet! Usually, the kids are VERY helpful at reminding you to give them their points!

## III. How to check on chores (without bugging the child - or you!)

	Each parent picks one and picks a time for checking on the chore. Usually, one chore is for the morning and one is for the evening but it can be any time the parents want. Each parent should check on the chore and record the points earned within 30 minutes everyday. [Single parents should still have 2 chores and 2 separate times for checking if they are completed.]
	Record the estimated check time on the sheet next to the chore.
	To check chores: 1. give them one warning, 15 minutes before. That's the only warning you give. 2. after 15 minutes, scoop up your child, and go through each step he did or didn't do. 3. Emphasize the number of points he earned (not those he missed).
	Ask, "What if, as you begin to check, your child quickly does a step. What would you do?" "Sorry, I can't give you those points today, but if you have them done tomorrow before I start checking, then you will get the points!"

	TRAINING SCENARIO Say, "O.K., let's try some training examples."	Parent Response
	Look at the first chore you have selected for your child. How many points would your child get for completing the first and third step, but not the second? (Two)	
	What if they finished step 2 right after you walked into the room? Would you give that point? (No)	
	Can you ever take points away once they earned it? (No)	
	How long of a warning do you give before checking on a chore? (about 15 minutes)	
	Is it ok to list rewards which you can't guarantee? (No)	
	Do you give points for compliances which happen any time during the day? (yes)	

IV. To review points each day.

	Set a time to review points with child every night (at least a half hour before bedtime, but night if at all possible).
	At the designated time, review the day. 1. the number of points for compliances (don't mention 15") 2. the number of points for chores Review the choices and let him pick. Give reward if it's tangible, talk about the social reward as if you are really excited for him/her. Don't steer the child away from any of the rewards - keep your end of the bargain!
	If s/he doesn't meet the point total, this is positive! This is how the child learns that good things happen when they do well and mind their parents. If a child misses their point total, say "Well, you didn't get your points today, but maybe tomorrow you will. Tomorrow's a brand new day! If you get XX points, then you can choose from all those good rewards!"
	DO NOT NAG! NAGGING IS NOT ALLOWED HERE! The point system is for encouraging the child, not threatening them. If the child says he doesn't care, or tries to get you into a fight, don't give in. Don't let the child's behavior change yours. You go through your routine here, regardless. You should be encouraging at all times when reviewing points, even if you are mad about something the child did that day. By the way, if he earns his points he gets his reward even if he was especially difficult or bratty at some point of the day.

V. How to explain it to the child.

	Get rewards in house first. You must be able to provide any reward you offer so he can depend on you keeping your end of the bargain!
	At bedtime, tell your child "You do things we really, really like. And we want you to do even more. So to help you we want to give you a chance to earn points. By getting enough points you can get x,y, and z." Mention the chores, but emphasize the rewards. Then explain the chores as follows.
	To explain the chores, you do it for them, step by step ONCE, explaining as you go. Then the Positive Point Program starts the next day!

V. Review the parent's jobs

	- note the reward chosen per day
	- get grab bag together before you explain the program
	- your child can earn points all day long so make sure you give them to him!
	- At the same time, I want you to continue the 1 hour weekly observations in addition to other things you are doing. This way, we are still tracking how his noncompliances and compliances during those high request periods we selected earlier.
	- give a call if you have any questions
	[If possible, copy their chart w/writing so that you have a record of their plans]
	Now, before you leave I want to double check that we have covered everything. This is your quiz for today - I'll tell you if missed anything when we are done with all ten questions. Ready?

TESTING SCENARIO	Parent Response
Say, "O.K., now we want to make sure we taught you everything you need to know. Here's the quiz!"	
1. Show me where you record the child's total for each day?	
2. When you first explain the chores for the child, who actually does the chore?	
3. Is it ok to steer the child away from any of the listed rewards?	
4. Imagine a day where your child gets all their chore points and is good enough	



	for most of the day to make the target point total. However, he disobeys you right after supper. When you review the day with him before bedtime, does he still get his reward for that day?	
	5. If you ask your child to clean up their toys and they begin the task within 15 seconds, but don't finish it before then, do they still get their points for compliance?	
	6. If your child complies with your request what do you do?	
	7. How many points does your child need to get to meet their daily point total?	
	8. When you are reviewing your child's daily point total, which would it be correct to say?..... " I am very upset that you didn't meet your point total. You have disappointed me once again. You'd better work harder tomorrow, or else!" <u>OR...</u> " Well, you didn't get your points today, but maybe tomorrow you will. Tomorrow's a brand new day! If you get XX points, then you can choose from all those good rewards! "	
	9. If your child successfully completes all steps of both of their chores, how many points will they get?	
	10. How many warnings do you give your child before checking on their chore?	

Quiz Two - Answer Key

1. On the recording form
2. The parent
3. No
4. Yes- if he earns his points, your contract with him is that he gets his reward. After next week, you will have a specific response for when he doesn't mind you, so please be patient until then!
5. Yes, the child only has to start the task within 15 secs, they don't have to complete the task within 15 secs
6. Give them a point
7. This amount was agreed upon earlier in this session
8. The second choice is correct
9. This amount was agreed upon earlier in this session
10. Just One

### Session 3: TIME-OUT PROCEDURES

	<p>[Review parent's homework (positive point program)</p> <ul style="list-style-type: none"> <li>- point out any positive results/effectiveness in helping child to learn new behavior</li> <li>- review unsuccessful days &amp; parent's response]</li> </ul>
	<p>[Verify that the parent gave rewards when the point totals were reached and withheld rewards when the points were not achieved. If child missed point total, clarify that that is good! It is a chance for the parent to show they will keep their end of the bargain and that certain standards must be met.]</p>
	<p><b>* DO NOT BEGIN THE TIME-OUT PROGRAM UNTIL THE POSITIVE POINT PROGRAM IS IN PLACE!</b> Criteria: The child must have been in the Positive Point Program for a week and the child should not have missed his reward on more than 2 out of 7 days once the program is started. If the child missed their total for more than 2 days of any week since starting, explore why the program isn't working. Review reports of the child's behavior and review any obstacles the parents may be facing in implementing the program. If the parents don't understand the Positive Point Program, spend the session reviewing it. If the parents understand it and will be able to implement it, go ahead and review the time-out program but tell them to delay starting it until their child is successfully hooked into the Positive Point Program.</p>

#### I. Introduction: Topic - how to decrease undesirable behavior.

	<p>- Inconsistent punishment is worse than no punishment at all. Often parents are tired, distracted, busy, etc. so that they yell, spank or whatever on an inconsistent basis. If you punish inconsistently, kids will start spending time trying to figure out if the parents really mean it or not when they ask the child to do something. They get more interested in figuring out if the parents are really going to punish or not and, consequently, the kids don't get into the good habit of simply getting up and doing what the parent asks.</p>
	<p>- Time-out is designed as a non-physical, non-hassle punishment. You can use this punishment even when you are tired or on the phone. You may have tried other forms of time-out but the kind we will teach you is the most effective version we have seen.</p>
	<p>- By definition, t.o. is designed to remove a child from positive attention (i.e., removing the child from social reinforcement). Another benefit is that it helps keep things from getting really negative between parents and children- when things get too negative, no learning takes place.</p>
	<p>The goal here is to pair boredom with problem behaviors while removing everyone from a conflict situation. Here's how to do it.</p>

#### II. Timeout is a little complicated - there are a number of pitfalls.

	<p>- One piece of crucial equipment is a timer that dings when time-out is over. This helps avoid arguments/discussions. Keep in mind that any interaction during time-out negates the value of the punishment. The timer will take the discussion out of it.</p>
	<p>- Where to do it: think of a boring place to sit, a room with a door. Typically, parents choose the main floor bathroom (w/o toys, medications, poisons, breakables).</p>
	<p>- How to do it - Time: research shows the ideal amount of time is about 5 minutes. This time is enough to be boring, but it is not too disruptive. Research suggests there is not any benefit to long time-outs.</p>
	<p>- What's it used for? Non-compliance with your requests. So for now on, every compliance equals a point, and every noncompliance equals a time-out. Do NOT subtract points or rewards - if your child has earned their reward, they should get it. Your contract doesn't allow you to take it away!</p>
	<p>- What to say: "That's not minding. Take a time-out." You are trying to teach that it's better to go to time-out than to not go. What should happen now is that your child will get up and walk directly to the bathroom closing the door behind him. You will set the timer, then 5 minutes later it dings and he will walk out quietly.</p>

	You may be thinking, "my kid is not going to go without a fight." Hopefully, that's true early on - I'll explain why in a minute.
	- Parents have 2 lines of defense.
	(1) Parents' only response is "That's one more minute," or, "That's another minute, that's a total of X minutes." You may go up to 10 minutes for a time-out. So let's review how the first line of defense works.

	TRAINING SCENARIO Say, "O.K., let's try some sample questions."	PARENT'S RESPONSE (circle one)
	(Give/get examples of how a child may earn 1 more minute.) You ask your child to wash his hands and he says "I don't want to." You say, "That's a time-out!" He says, "I'm not going!" What do you say?	
	Then he stomps his foot. What do you say?	
	Then mutters something. What do you say?	
	Then he slams the door. What do you say?	

	(2) The second line of defense is as follows. If you get to 10 minutes, you must say, "That's ten minutes. If you don't go to time-out now, you lose _____." Now, this blank/thing is what we call the "backup" or the "backup punisher." Here you will remove some positive privilege or some important thing that you can take away. Your child must think it is HORRIBLE! If you get to 11 minutes, just say "O.K., forget the time-out, no _____!" You MUST follow through.
	So, let's think of some backup punishers. Some parents choose things like: no t.v. for the evening, no electronic games, having an early bedtime (1 hour earlier) that day, locking up their bike, rollerblades, or skateboard for the rest of the day, forbid playing in some room.
	Backup punishers should be lost just for the rest of the day. We want your child to be able to start everyday with the possibility of making that day a good one. If the backup is given at bed-time, you can have the privilege or item be lost for part of or for the entire next day. Avoid taking something away for longer than a 24 hour period for children this age.

### III. How to explain things to the child:

	- Get the timer in the house first.
	- At bedtime the night before you are to begin, say "Now we're going to do something new. You've been doing really well with getting points and we're really proud of you. Now when you don't mind, we are going to do something called time-out... [Explain 5 minutes, minute-adding, 10 minute limit, and backup punishers. Then role-play it with your spouse if the child won't go. Role-play first with the child doing different things to earn minutes until time-out is forgotten and the back-up is given. Then role-play with time-out going smoothly. Afterwards, give your child a hug and a smile, and tell him/her how proud you are that they are such good learners.

### IV. What to do when timing doesn't permit time-out because it's inconvenient for you or maybe better for the kid. Examples?? Could be at bedtime, when the bus arrives for school, or right before going to somewhere he doesn't want to go (shopping, a doctor's appointment, etc.).

	- When your child seems to prefer time-out to something else, say "That's a time-out. You'll serve it _____ (e.g., when you get home, in the morning)."
--	---

	- Always use time-out for a noncompliance - even if you are tired.
	Are you willing to try this strategy at home?
	Next Week: we'll talk about ways to do time-out away from home.
	I need to give you a warning! Behavior usually gets worse before it gets better, especially if you have ever backed off from punishment before. The child will test you & you must follow through!
	Remember to call if you have questions or just need some moral support. It's better to call than go a whole week with a time-out related problem.
	Be sure to keep up the tracking at home. We want you to continue that while your child is in this program so we know exactly how he is doing.

	KNOWLEDGE CHECK Say, "O.K., let's find out if we covered everything. Ready for the quiz?"	PARENT'S RESPONSE (circle one)
	1. What important piece of equipment must you have before you begin to use time-out?	
	2. Let's say that you make a request of your child and they are noncompliant. You should send them to what? (time-out)	
	3. Then they walk in the bathroom and quietly close the door as they are supposed to - how long do you set the timer?	
	4. Let's say you've given your child a time-out but s/he continues to misbehave. What is the only thing you can say? ("That's one more minute" or "That's another minute - that makes a total of 6 minutes.")	
	5. What's the longest time you can keep your child in time-out? (10 minutes)	
	6. If you get to ten minutes for a time-out, what warning do you give your child after you say, "That's ten minutes." ?	
	7. If your child continues to be noncompliant with time-out, what do you say at this point?	
	8. Let's say that you ask your child to wash his hands and he says, "I don't want to." You tell him that's a time-out and he says, "I don't care." What do you say?	
	9. Then he stomps his foot and says " You can't make me." What do you say?	
	10. What if he gets up to 10 minutes - what do you say?	

Quiz Three - Answer Key

1. A timer
2. Time-out
3. Five minutes
4. "That's one more minute" or "That's another minute- that makes a total of 6 minutes."
5. Ten minutes
6. "If you don't go to time-out now, you will lose X."
7. "O.k., forget time-out, no X for the rest of the day."
8. "That's another minute."
9. "That's another minute."
10. "That's ten minutes, if you don't go to time-out now, you will lose X."

**Common Obstacles and Possible Solutions in Therapy**

OBSTACLE/OBJECTION	POSSIBLE SOLUTION
<p>1. Parents often feel they have tried everything or that they have tried behavior modification (i.e., rewards or time-out) at home before.</p> <p style="text-align: center;">OR</p> <p>2. I don't have time right now.</p>	<p>THIS IS DIFFERENT AND WE KNOW IT WORKS FOR MOST FAMILIES - WE ARE USING THE MOST EFFECTIVE, EMPIRICALLY VALID APPROACH AVAILABLE. AS PARENTS, YOU WILL KNOW WITHIN 3-4 WEEKS IF THIS PROGRAM WILL WORK FOR YOU. ALL YOU HAVE TO DO IS LISTEN CLOSELY, USE THE STRATEGIES WE AGREE UPON, AND THEN WAIT ABOUT A MONTH. IF IT DOESN'T WORK, YOU HAVEN'T LOST MUCH TIME. IF IT DOES WORK, YOUR INVESTMENT WILL PAY YOU BACK MANY TIMES WHAT YOU PUT INTO IT. SHOULD WE POSTPONE TREATMENT FOR A WHILE OR WOULD YOU LIKE TO GIVE IT A GO THIS WEEK?</p> <p style="text-align: center;">OR</p> <p>WHAT WILL IT MEAN TO YOU AND YOUR CHILD IF YOU POSTPONE TREATMENT FOR A WEEK OR A MONTH OR IF YOU SIMPLY DECIDE TO DO NOTHING RIGHT NOW? IS YOUR CHILD AT RISK TO BE SOCIALLY REJECTED BY OTHER KIDS? IS YOUR CHILD AT RISK OF ALIENATING A TEACHER? CAN YOU PUT UP WITH THINGS AT HOME IF THEY DON'T CHANGE?</p>
<p>3. I don't want to make my kid a robot.</p>	<p>I DON'T EITHER. THIS PROGRAM ISN'T MEANT TO CREATE ROBOTS OR SQUASH CREATIVITY OR SUPPRESS EMOTIONS. IT SIMPLY HELPS CHILDREN LEARN SOME IMPORTANT HABITS WHICH WILL PROBABLY HELP THEM GET ALONG BETTER WITH ADULTS AND OTHER KIDS WHILE AT THE SAME TIME ENCOURAGING THEM BE MORE HELPFUL AT HOME AND MORE SUCCESSFUL AT SCHOOL. WE WILL BE FOSTERING A WORK ETHIC, WE WILL TRY TO POINT OUT THAT HOW ONE ACTS USUALLY AFFECTS THE OPPORTUNITIES ONE HAS, BUT THIS ISN'T INCOMPATIBLE WITH BEING A KID, BEING CREATIVE, OR HAVING FUN. I WON'T ASK YOU TO DO ANYTHING AT HOME THAT YOU ARE UNCOMFORTABLE WITH. YOU WILL HAVE THE OPPORTUNITY TO ACCEPT OR REJECT ANY PORTION OF THE TREATMENT PACKAGE, O.K.? IF THIS IS O.K., MAKE SURE YOU TELL ME THE VERY FIRST TIME YOU ARE UNCOMFORTABLE OR HESITANT. I WANT TO MAKE SURE WE DO THINGS</p>

	THAT ARE CONSISTENT WITH YOUR VALUES AND YOUR GOALS FOR YOUR CHILDREN.
4. I'm willing to do it but my husband isn't. He says he doesn't have any problems with our child and that I should get the help.	WHAT WE'VE FOUND IS THAT A CHILD WHO HAS PROBLEMS WITH ANY PARENT WILL PROBABLY HAVE TROUBLE WITH OTHER ADULTS, IF NOT NOW, THEN LATER ON. WE ALSO HAVE NOTICED THAT THERE ARE A LOT OF REASONS FOR WHY ONE PARENT SEES PROBLEMS WHILE THE OTHER DOESN'T. SOMETIMES, IT'S BECAUSE ONE PARENT SPENDS MORE TIME WITH OR HAS TO MAKE MORE UNPLEASANT REQUESTS OF THE CHILD (LIKE GET READY FOR SCHOOL, DO YOUR HOMEWORK, FINISH YOUR CHORES, ETC.). ANYWAY, IF ONE PARENT ISN'T HAVING ANY BIG PROBLEMS, THAT'S A GOOD SIGN - IT GIVES US SOMETHING TO BUILD ON. I'D LIKE TO BE ABLE TO TELL YOUR HUSBAND THAT WE ESPECIALLY NEED HIM TO HELP US FIGURE OUT WHAT WORKS AND WHAT DOESN'T WORK. IT COULD SAVE US A LOT OF TIME. DO YOU THINK IF I SAID THIS TO YOUR HUSBAND THAT HE MIGHT COME TO OUR FIRST SESSION? IT REALLY HELPS WHEN BOTH PARENTS AGREE ON HOUSEHOLD STANDARDS AND DISCIPLINE APPROACHES. HIS COMING WILL BE A BIG HELP TO BOTH YOU AND YOUR CHILDREN.

### Miscellaneous Thoughts

*What is the role of this program in teaching children to express their emotions?* This program does not directly teach emotional self-expression. Note that time-out procedures afford children and their parents time away from destructive, accelerating interactions (e.g., yelling matches where hurtful things are often said or done) and allow the child time to gain control over their often high levels of physiological arousal. For families with aggressive or noncompliant children, it seems more appropriate to initially target both compliance and self-control and then to later target self-expression. Currently, teaching self-expression and emotional awareness are not included in this intervention package. However, parents are given tools which they can use to shape their child's ability to express how they are feeling.

*What if you suspect abuse?* Therapists who suspect that parents are abusing their children should review the case with the supervisor immediately and make sure that they are in compliance with the state laws mandating report of suspected abuse.

**Appendix K**

**Behavior Checklists for Therapist Adherence**

Therapist Research Number: \_\_\_\_\_  
Client Research Number: \_\_\_\_\_

112

## OBSERVER SCORING FORM FOR SESSION #1: TRACKING

### Introduction: Parent Training Program

- \_\_\_ Explain that each week we are intending to change behavior.
- \_\_\_ Week 1 involves seeing behavior and tracking it.
- \_\_\_ Week 2 involves rewarding positive behavior.
- \_\_\_ Week 3 involves punishing inappropriate behavior.
- \_\_\_ Explain that we will not teach punishment procedures until we have taught more positive ways of responding.
- \_\_\_ Explain that research suggests the program is effective for 8/10 families.
- \_\_\_ Explain that we will know if it is working for their family within about 4 weeks.

### Defining Compliance and Noncompliance

- \_\_\_ Give examples of start and stop requests.
- \_\_\_ Ask for common requests that parents make.
- \_\_\_ Explain that there are two ways a child can respond to a request (they can do it or not do it).
- \_\_\_ Introduce the "stranger rule" example.

#### Build the definition of compliance:

- \_\_\_ Doing what the child is told.
- \_\_\_ Beginning within 15 seconds.
- \_\_\_ No back-talking or arguing (optional: describe research on the issue).
- \_\_\_ No whining (optional: describe research on the issue).



Therapist Research Number: \_\_\_\_\_  
Client Research Number: \_\_\_\_\_

Review parents' responsibilities

- \_\_\_ Making normal requests.
- \_\_\_ Waiting 15 seconds to respond.
- \_\_\_ Monitoring and recording noncompliances and compliances on the observation sheet for one hour each day.
  
- \_\_\_ Instruct parents to call with any questions (387-8302).
- \_\_\_ Hand out knowledge check to parents.
- \_\_\_ Review answers on the knowledge check with parents.
- \_\_\_ Give parents the correct answers to the knowledge check.

Therapist Research Number: \_\_\_\_\_  
 Client Research Number: \_\_\_\_\_

## OBSERVER SCORING FORM FOR SESSION #2: POS. PT. PGM.

- \_\_\_ Review observation sheets to ensure that tracking was implemented properly during at least 5 of the 7 past days.

(\_\_\_ If tracking was not carried out properly, the therapist must not proceed with the Positive Point Program but must review the relevant steps from the Tracking session.)

- \_\_\_ Explain that the goal for this week is to increase desirable behaviors through the Positive Point Program:
  - \_\_\_ Stress the importance of implementing this program before any punishment procedures.
  - \_\_\_ Tell parents that increasing desirable behaviors will help simultaneously decrease negative behaviors.

### Selecting Target Behaviors to Increase

- \_\_\_ Present the Positive Point Program record form.
- \_\_\_ Provide examples of chores that have been broken down into steps.
- \_\_\_ Identify, with parents, two chores that can be done daily.
- \_\_\_ Break down each chore into 3-6 components.

### The Point System and Selecting Rewards

- \_\_\_ Describe the Program as a way by which their child can earn points towards rewards.
- \_\_\_ Tell parents that we do not consider this bribery.
- \_\_\_ Provide examples of types of rewards that may be used (ex. money, McDonalds/DQ, grab-bag, video, free time with mom or dad and saving for a big gift).

Therapist Research Number: \_\_\_\_\_  
Client Research Number: \_\_\_\_\_

115

- \_\_\_\_ Create a list of rewards to be used by parents.
- \_\_\_\_ Present child's reinforcer preference list to help generate reward choices..
- \_\_\_\_ Tell parents that they should be guaranteeable,
- \_\_\_\_ given every day or once/twice per week,
- \_\_\_\_ in a combination of tangible and social rewards.

### Getting From Compliances to Rewards

- \_\_\_\_ Explain that the child gets one point per compliance throughout the entire day.
- \_\_\_\_ Explain that the child gets one point for each step of the chore that is completed each day.
- \_\_\_\_ Decide on a point total for the first week (usually 1/2 of chore points plus 3-5 points).
- \_\_\_\_ Tell parents that every point (from compliances and chores) should be recorded on the recording form.
- \_\_\_\_ Decide where the chart will be kept in the house (e.g. a public place).
- \_\_\_\_ Tell parents that they may use a 3x5 card for recording if it is preferable to them.

### How to Check on Chores

Tell parents:

- \_\_\_\_ To pick a time to check on one chore per day (If there is a single parent, he/she must check on both chores).
- \_\_\_\_ To record the estimated check time on the sheet next to the chore.
- \_\_\_\_ To provide one (and only one) warning to the child 15 minutes before checking on the chore.
- \_\_\_\_ To check each step completed by the child 15 minutes after the warning has been given.
- \_\_\_\_ Not to award a point if the child completes a step of the chore as it is being checked for completion.

Therapist Research Number: \_\_\_\_\_  
 Client Research Number: \_\_\_\_\_

Give training scenario:

- \_\_\_ "Look at the first chore you have selected for your child. How many points would your child get for completing the first and third step, but not the second?" (Two)
- \_\_\_ "What if they finished step 2 right after you walked into the room? Would you give that point?" (No)
- \_\_\_ "Can you ever take points away once they have earned it?" (No)
- \_\_\_ "How long of a warning do you give before checking on a chore?" (about 15 minutes)
- \_\_\_ "Is it ok to list rewards which you can't guarantee?" (No)
- \_\_\_ "Do you give points for compliances which happen any time during the day?" (Yes)

How To Review Points

- \_\_\_ Tell parents to set a time to review points earned with their child each night:
  - \_\_\_ Review number of points earned for compliances.
  - \_\_\_ Review number of points earned for chores.
  - \_\_\_ Review reward choices and let child pick one.
  - \_\_\_ If point total has been met, parents should provide the tangible reward or talk excitedly about the social reward to be given later.
  - \_\_\_ If point total has not been met, parents should tell the child that he/she may meet the total and earn a reward tomorrow.
  - \_\_\_ When reviewing points, the positives should be stressed, not the negatives (NO NAGGING).

Explaining it to the Child

- \_\_\_ Remind parents to have rewards in the home before starting the program.
- \_\_\_ Tell parents to explain the program to their child (Ex. "You do things we really like...").
- \_\_\_ Tell parents that they must demonstrate each step of each chore for their child to ensure understanding.

Therapist Research Number: \_\_\_\_\_  
Client Research Number: \_\_\_\_\_

**Review parents' responsibilities:**

- \_\_\_\_ Note the reward chosen per day on the record form.
- \_\_\_\_ Continue to keep tracking the compliances and noncompliances each day for one hour (like they did the previous week).
- \_\_\_\_ Remind parents to call with any questions (387-8302).
- \_\_\_\_ Give the knowledge check form to parents.
- \_\_\_\_ Check/review parents' answers to the knowledge check.
- \_\_\_\_ Collect the knowledge check form and give them the correct answers and instructions for the next week.

Therapist Research Number: \_\_\_\_\_  
 Client Research Number: \_\_\_\_\_

### OBSERVER SCORING FORM FOR SESSION #3: TIME-OUT

- \_\_\_\_\_ Review the Positive Point Program sheet(s) to ensure that the child met his/her point total on five of the past seven days.

(\_\_\_\_\_ Do not proceed with Time-Out if point total has not been met on five of the past seven days. Instead, review the relevant objectives from the previous session.)

#### How to Decrease Undesirable Behavior

- \_\_\_\_\_ Provide rationale for a punishment procedure by explaining that inconsistent punishment is worse than no punishment at all.
- \_\_\_\_\_ Define Time-Out as a non-physical, non-hassle form of punishment.
- \_\_\_\_\_ One goal is to remove child from positive attention.
- \_\_\_\_\_ Helps to keep things from getting too negative between parents and child so that learning can still occur.
- \_\_\_\_\_ Main goal is to pair boredom with problem behaviors.

#### How to Use Time-Out Appropriately

Provide procedural components:

- \_\_\_\_\_ Parents need a timer with a loud ring.
- \_\_\_\_\_ Parents should decide on a boring place for the child to go (usually a bathroom).
- \_\_\_\_\_ Five minute time limit (provide research rationale if necessary).
- \_\_\_\_\_ Each compliance still earns the child one point.
- \_\_\_\_\_ Each noncompliance earns the child a time-out.
- \_\_\_\_\_ Points or rewards should not be subtracted following noncompliant behavior.

Describe a problem-free Time-Out procedure:

- \_\_\_\_\_ Parents say, "That's not minding, take a time-out".
- \_\_\_\_\_ Child gets up and walks to the time-out area.
- \_\_\_\_\_ Parents set timer for five minutes.
- \_\_\_\_\_ When timer dings, child exists the time-out area quietly.

Therapist Research Number: \_\_\_\_\_  
 Client Research Number: \_\_\_\_\_

Introduce first line of defense for a child who does not comply with goint to time-out:

- \_\_\_ Adding one minute to time-out if child does not comply.
- \_\_\_ Parents should say, "That's one more minute" or "That's another minute, that's a total of X minutes."

Training Scenario, therapist should say:

- \_\_\_ "You ask your child to wash his hands and he says 'I don't want to'. You say "That's not minding, take a time-out." He says, 'I'm not going.' What do you say?"
- \_\_\_ "Then he stomps his feet. What do you say?"
- \_\_\_ "Then he mutter something. What do you say?"
- \_\_\_ "Then he slams the door. What do you say?"

Introduce second line of defense for a child who continues to be noncomplaint:

- \_\_\_ Can use minute-adding up to 10 minutes.
- \_\_\_ After 10 minutes, parents should say "That's ten minutes, if you don't go to time-out now, you will lost XXX" (some privilege).
- \_\_\_ Provide examples of back-up punishers (ex. early bedtime, no tv for the night, etc.).
- \_\_\_ Formulate a list of back-up punishers with parents.
- \_\_\_ If parents get to 11 minutes, they should say "O.K. forget the Time-Out, no XXX (back-up punisher)".
- \_\_\_ Explain that a privilege should not be taken away for longer than 24 hours.
- \_\_\_ Explain that if a back-up punisher is given at bedtime, the privilege may be lost the following day.

#### Explaining it to the Child

Tell parents to introduce Time-Out to their child ("We are going to start something new tomorrow..."):

- \_\_\_ Explain time-limit, minute-adding and back-up punishers.
- \_\_\_ Role-play with child or spouse.
- \_\_\_ Get timer in the house before starting time-out.

Therapist Research Number: \_\_\_\_\_  
Client Research Number: \_\_\_\_\_

120

Additional Concerns about Time-Out

- \_\_\_ Explain that parents may have the child serve time-out at a later time if the situation so warrants.
- \_\_\_ Remind parents to always use a time-out for every noncompliance (ex. even if they are tired).
- \_\_\_ Warn parents that behavior often gets worse before it gets better.
- \_\_\_ Remind parents to call with any questions (387-8302).
- \_\_\_ Remind parents to keep up the Positive Point Program and tracking compliances and noncompliances for one hour per day as well.
- \_\_\_ Give the knowledge check to parents.
- \_\_\_ Review their answers.
- \_\_\_ Collect knowledge check and give handout with correct answers and instructions to parents.



**Appendix L**  
**Skills Check Form**

1. Compliance and Noncompliance - Compliance is defined as the child beginning the command within 15 seconds with no backtalk, arguing, or whining. Noncompliance is anything else. For example, if a child is asked to come to the table, and he waits for five seconds, closes his book and begins walking to the table, that is a compliance. However, if the child waited for 15 seconds before moving, or if he pouted or whined, or said "I don't want to" or even "Do I have to?," that would be a noncompliance.

2. Reward - Correct administration of a point will include both verbal recognition of the child's compliance (typically praise) and parental recording of a point. For example parents could say, "Good job, Susie. I like the way you turned off the bathroom light. That's a point," or simply, "That's a point." Any other response would be considered incorrect.

3. Time-Out- Several steps are involved in correctly administering the time-out procedure.

a. The correct beginning of time-out from reinforcement is for the parent to say, "That's not minding. That's a time-out," or simply, "That's a time-out." Any other beginning (e.g., a lecture or scolding) will be considered incorrect.

b. The parent must use the timer's bell to indicate when time-out is over. Any other ending (e.g., speaking to the child to indicate time is up) is incorrect.

c. If minutes are to be added for further noncompliance, the correct way to do this is to say, "That's another minute," or "That's another minute. That's a total of X minutes." Time-out is only to be used for a maximum total of ten minutes. All other responses (e.g., explanations or lectures) will be considered incorrect.

d. Backup Punisher - The backup punisher is used only after the parent has reached the maximum time-out of ten minutes. The parent must deliver a warning, "That's ten minutes. If you don't go to time-out now, you will lose X." If the parent then observes further child noncompliance, they should say, "Forget time-out. No X for the rest of the day [or for tomorrow, if the behavior occurs late in the evening]." Any other response will be considered incorrect.

**Appendix M**  
**Procedures to Train Home Observers**

## Home Observer Training Procedures

a. Observers will have read the parent training manual before this training session. Introduce observers to the list of targeted skills to familiarize them with parent training concepts.

b. Hand out the Skill Check form and get to the details...

1. Code - Understand the function and use of code numbers

identify subjects' code numbers

protecting confidentiality of data

2. Time arrived-record the time that the observer arrives.

3. Time at beginning of recording-observers should record their beginning time when they are in place and ready to record.

4. Time at end of recording-after 60 minutes of recording time have passed (or the conclusion of a request interaction that is in progress when the 60 minutes is up), observers should record the time in this box and end their recording for that session.

5. Identify request-record a two or three word response identifying what the parent request was, such as "Lights off" or "Bike away" or "Set table." Multiple step requests will be treated as a single request for the purpose of this observation scheme. This means that children must complete all steps of these requests in order to be awarded a compliance.

6. Warning given-the parent is allowed to give the child one warning regarding time-out. For example, "Sam, put your bike away now, or that's a time-out." The parent must include the idea that a time-out is coming if the child doesn't comply. A warning is not necessary, and a correct time-out can be given without a warning, but this is something that parents can do if they want to make sure that the child understands that they must comply or a time-out is going to follow.

7. Compliance-a compliance is a child beginning to do the parent request within 15 seconds with no arguing, backtalk or whining. The child does not have to actually finish complying with the parent request within 15 seconds.

8. Noncompliance-a noncompliance includes any child response (to a request) which is not a compliance. Examples include: ignoring the parent, backtalking, whining, tantruming, or running away.

9. Gives point-this refers to the parents' verbal response to the child's behavior. They must tell (or motion to) the child that they have earned a point and then actually record the child's point. For example, the parent may say "Sam, I like the way that you turned off the basement light for me. That's a point [said while jotting the point down on their 3 x 5 card]."

10. Gives initial TO correctly-This involves the parent waiting for 15 seconds, and then informing the child that they have a time-out. This should not involve any argument or discussion. The parent should simply say, "Sam, that's a time-out."

11. Doesn't give initial TO correctly-This could involve the parent not waiting for 15 seconds, the parent arguing with the child, the parent threatening the child, the parent giving another warning, etc. If the TO given by the parent is not scored as correct, it is scored as incorrect.
12. Parent does nothing-this occurs when the parent makes a request of the child, the child responds, and the parent doesn't follow through with either providing a point or a time-out. The parent simply does not respond to the child behavior at all.
13. Parent misidentifies child's response-this occurs when the parent treats a child compliance as a noncompliance or vice versa. For example, if Sam does turn off the basement light as requested his parent treats his behavior as a noncompliance and gives him a TO. Or, if Sam doesn't turn off the basement light as requested, which is a noncompliance, and his parent gives him a point for compliance.
14. Parent records child's behavior-this box is checked if the parent records either a point for the child or a noncompliance for the child. This recording will be made either on a notecard or on the record sheet that the parent keeps posted. There is no specific time during which the recording has to be made, so even if the parent goes back later and records the information, the observer can go back later and check this box.
15. Used timer-this box is marked if the parent uses the timer correctly for TO. In order to be used correctly, the timer must be set for the correct number of minutes by the parent and placed outside of the TO area while the child is in TO.
16. Used timer incorrectly-this box is marked if the parent either didn't use a timer or used the timer incorrectly. Using the timer incorrectly could involve setting the timer for the incorrect amount of time, placing the timer somewhere where the child cannot hear it ring, or allowing the child to set the timer or take it into TO with them.
17. Added minutes-this box is checked if the parent correctly adds minutes to their child's TO. The only correct way to add minutes is to wait for 15seconds after giving the TO, unless the child actively noncomplies, in which case the parent doesn't need to wait the 15 seconds. After waiting or an active noncompliance, the parent says, "Sam, that's another minute." Or, "Sam, that's another minute, for a total of X minutes." The parent should not discuss the issue with the child, but should simply give the added minutes.
18. Added minutes incorrectly-this box is checked if the parent does not add minutes correctly or misses adding minutes which should be added. For example, Incorrect adding would be checked if the parent gives the wrong number of minutes, adds minutes for more than a total of ten minutes (or for a total of less than ten minutes), or argues or discusses the issue with the child. This box would also be checked for instances where minutes should have been added but weren't.
19. Assigned backup-this box is checked if the parent correctly assigns the backup punisher. The backup punisher is used after the parent has given the total of ten minutes of time-out and then warns the child, "Sam, that's a total of ten minutes of TO. You either go to TO now or you will lose X (the backup punisher)."
20. Assigned backup incorrectly-this box is checked if the parent does not give the backup punisher correctly. For example, the parent may threaten or argue with the child, may not give the agreed upon punishment, or may give up after adding all the minutes and not assign the backup punisher at all.

21. Ends TO incorrectly-this box is checked if the parent does not end TO correctly. The only correct way to end TO is to not converse with the child but to simply allow the ding of the timer to signal to the child that TO is over. If the parent converses with the child during TO, or tells the child verbally or by opening the door that TO is over, this box should be checked.

c. Added info...

1. A separate box (row) should be used for each parent request made. There are two boxes per sheet.
2. During the session, observers should be seated in a discrete place from which they can observe as much interaction as possible.

Observers should appear as unobtrusive as possible during the session and should avoid as much interaction with the family as possible until the session is over. Observers should not stare, or ask questions of parents or other family members during the session. We want the families to be as comfortable as possible with our presence!

3. Observers will get their home observation schedule assignments from the Training Coordinator.

Two hours should be allowed for each session to include time for getting the observer kit, travel to the home, the one hour session, any follow-up necessary with the parents, return of the observer kit, and triple-checking the coding sheets for clarity and legibility.

4. Observers must make arrangements to return the coding sheets immediately to the Training Coordinator.

d. Questions asked during or after the session...

1. From the child-if the child inquires as to your presence, simply tell them that you attend school at the university and that you have to spend time in family's homes and observe how families are at home. Mention that your instructor has strict rules that you aren't allowed to interfere with how kids and parents normally act at home, "...so that's why I can't talk to or play with you. You just go ahead and do what you normally do, OK?" Be apologetic in tone and then try to be as vague as possible.
2. From the parent(s)-if the parent(s) ask questions about the intervention, you may only answer questions about the observation session - you are not to provide any advice regarding the intervention program. If they press for specific information, ask them to call their Training Coordinator or to their Therapist. It's permissible to say that you haven't been trained to answer any treatment related questions and that you aren't even allowed to guess.

E. The role play examination-distribute five Skill Check forms and pencils to the observers.

Explain that in order to begin to observe, they must correctly record the following 10 parent-child interactions. Complete the role plays from Appendix G and allow the observers to record. They must achieve agreement of at least 95% with the expert recordings before they can begin to observe live families. Agreement is calculated by  $(\text{Agreements}/(\text{Agreements}+\text{Disagreements}))$ .

Kits for Home Observers should include:

- tape recorder and a 60 minute audiotape
- extra batteries (or extension cord) and an extra audio tape
- at least 40 recording forms
- three pencils w/erasers
- a digital watch or stopwatch with a second hand
- a clipboard

## **Appendix N**

### **Human Subjects Institutional Review Board Approval**





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## WESTERN MICHIGAN UNIVERSITY

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Date: November 3, 1995

To: Maria Channell

From: Richard Wright, Chair

Re: HSIRB Project Number 95-05-01

This letter will serve as confirmation that the changes to your research project "Does reinforcer preference predict outcome of a parent training program?" requested in your memo dated November 1, 1995 have been approved by the Human Subjects Institutional Review Board. These changes are:

1. Expanded coverage to include girls as subjects in this study.
2. Waiver of payment for participants in this program (with revisions to the recruitment flyer).

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 3, 1996

xc: Kevin Armstrong, PSY

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