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THE TREATMENT ACCEPTABILITY OF A BEHAVIORAL
PARENT TRAINING PROGRAM AND ITS COMPONENTS

by

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Abstract

Treatment acceptability research has typically examined the acceptability of single isolated procedures rather than a comprehensive program of integrated procedures designed to deal with a problematic behavior. One such program developed to treat child noncompliance and other conduct-disordered behaviors is the Forehand-McMahon parent training program (1981). This program has been extensively evaluated and its effectiveness, generalizability, and social validity have been documented in numerous investigations (see McMahon & Forehand, 1984, for a review). In this study, the treatment acceptability of the Forehand-McMahon parent training program (1981) was evaluated in terms of its five individual parenting skills (attends, rewards, ignoring, commands, time out), three methods of introducing each new skill to the child (presenting a rationale, presenting a rationale and modeling its use, or no rationale or modeling), and the program as an entity.

Ninety nonreferred mothers of 3- to 8-year old children were presented with written descriptions of the Forehand-McMahon parent training program as it would be applied to a typical clinic-referred family. Subjects were randomly assigned to one of three groups by way of the written descriptions they received. These descriptions varied only in the method of introducing each new skill to the child. Subjects evaluated each of the individual parenting skills, the teaching method, and the overall program by way of the Treatment Evaluation Inventory (Kazdin, 1980a; 1980b) and the usefulness/difficulty measures of the Parent's Consumer Satisfaction Questionnaire (Forehand & McMahon, 1981).

Subjects rated all aspects of the program very positively on overall ratings of acceptability suggesting that they perceived the program and its skills to be appropriate for the problem described, fair, sensible, and humane. Rewards, commands, and attends (strategies to increase deficit behavior) were rated as more acceptable than time out and ignoring (which attempt to reduce behavioral

excesses). In terms of the methods of introducing each new skill to the child, presenting a rationale was rated as more acceptable than either presenting no rationale or presenting a rationale and modeling its use. Ratings of treatment acceptability were positively correlated with ratings of usefulness and negatively correlated with ratings of difficulty. The ordering of techniques on usefulness and difficulty dimensions directly paralleled ratings of acceptability with only one exception. Comparisons of these findings with previous studies of treatment acceptability and consumer satisfaction are made and discussed in light of the social validity of this parent training program.

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Introduction

In recent years, there has been discussion of the need to broaden criteria for evaluating psychological treatments other than traditional outcome measures such as measures of behavior and attitude change (Barlow, 1981; Bornstein & Rychtarik, 1983; Garfield, 1983; Jacobson, Follette, & Revenstorf, 1984; Kazdin, 1977; Kazdin & Wilson, 1978; Strupp & Hadley, 1977; Wolf, 1978). Obviously, the focus on outcome measures of client change has had priority and will continue to have priority since the primary goal of clinical research is to develop effective treatment techniques. However, other criteria have been proposed to supplement outcome measures and include considerations of cost, efficiency, therapist expertise, duration of treatment, proportion of clients who improve, and side effects (e.g., Kazdin, 1980c).

Wolf (1978) has proposed that applied interventions be socially validated. Social validity refers to assessments of the social acceptability of intervention programs and would require validation of three types:

- (1) The social significance of the goals. Are the specific behavioral goals really what society wants?
- (2) The social appropriateness of the procedures. Do the ends justify the means?
- (3) The social importance of the effects. Are consumers satisfied with the results? All the results, including unpredicted ones? (p. 207)

Since Wolf's delineation of social validity, researchers in the field have focussed on three areas: the assessment of the clinical importance of behavior change, consumer satisfaction, and treatment acceptability. Two methods of determining the clinical importance of behavior change have been outlined by Kazdin (1977). Social comparison refers to comparing the client's behavior to that of the behavior of his or her nondeviant peers both before and after treatment. For treatment to be socially valid, the behavior of the client after treatment

should be indistinguishable from his or her peers. The subjective evaluation method refers to having individuals who likely have contact with the individual (for example, parents, spouse, teacher) assess the client's behavior to determine whether the changes made during treatment are viewed as qualitatively important (Kazdin, 1977).

Consumer satisfaction refers to satisfaction with treatment outcome measured after treatment completion and may also include "satisfaction with the therapist, with various treatment procedures or skills, and with the teaching format employed in the treatment program" (McMahon & Forehand, 1983, p. 210). Satisfaction with treatment or consumer satisfaction has been a feature of evaluation research in community mental health for many years (Lebow, 1982; McMahon & Forehand, 1983). As a type of social validation among behavior therapists and researchers, consumer satisfaction has been a method of expanding outcome measures to include client feedback. According to McMahon and Forehand (1983), the most extensive use of consumer satisfaction measures in the behavioral treatment of children has been in the area of parent training.

As defined by Kazdin (1980a), treatment acceptability refers to "judgements about the treatment procedures by non-professionals, laypersons, clients, and other potential consumers of treatment." (p. 259) Included in judgements of acceptability are considerations of appropriateness of treatment for the problem; whether treatment is just, sensible, and nonintrusive; and whether treatment concurs with popular notions of what treatment should be. In sum, treatment acceptability refers to the overall evaluation of the treatment procedures (Kazdin, 1980a).

The case for evaluating treatment acceptability is justified on several grounds. Examining treatment acceptability provides an opportunity to understand the process of psychotherapy from the client's perspective since the opinion of the

client on the suitability, usefulness, and so on of the therapy is sought. Also, for certain clinical problems, there are several effective techniques available (Kazdin, 1980b). For example, the techniques of differential reinforcement, time out, response cost, and positive practice have all been found to be effective in reducing various disruptive child behaviors (Gelfand & Hartmann, 1984). Though these techniques have been shown to be effective, they may be differentially acceptable to the client (McMahon, Cross Calvert, Davies, & Flessati, 1986). Treatment procedures often raise ethical and legal issues since some procedures may infringe upon client rights, regardless of their effects on behavior (Kazdin, 1980b). This is especially pertinent in the treatment of children, the mentally retarded, the institutionalized mentally ill, or anyone incapable or unable to give informed consent. Research in treatment acceptability addresses concerns regarding methods used to obtain client change (Kazdin, 1980b).

Treatment procedures viewed by society as more acceptable are more likely to be sought out and adhered to once treatment has begun (Kazdin, 1980b). It is likely that acceptable treatment procedures will result in fewer dropouts, greater client compliance, and greater overall satisfaction with treatment. Measures of treatment acceptability may predict who will drop out of therapy. By identifying variables that influence clients' reactions to treatment, effective treatments that have low acceptability might be altered so as to become more acceptable (Kazdin, 1980b). Additionally, there are likely certain subpopulations that would find some interventions more acceptable than would other subpopulations. For example, parents of children with severe behavior problems might rate intrusive treatment interventions as more acceptable than would parents of children with mild behavior problems. It would be important then to identify these subpopulations so that treatment procedures can be matched to particular client groups.

Finally, policy makers and the public have become concerned with the credibility, usefulness, and accountability of various interventions employed in mental health services. In evaluating treatment acceptability, the public can be reassured by other consumers that interventions are acceptable and appropriate (Parloff, 1983).

Researchers have sometimes confused consumer satisfaction with treatment acceptability. For example, Hobbs, Walle, and Caldwell (1984) described a study in which mothers of noncompliant children evaluated one of three parent training conditions after having been trained in that particular technique. Similarly, Walle, Hobbs, and Caldwell (1984) had mothers of noncompliant children evaluate the acceptability of time out and attention after administering these techniques in various sequences and combinations (time out followed by attention, attention followed by time out, or attention and time out administered concurrently). Both studies discussed their results in terms of acceptability of treatment when it clearly falls under the rubric of consumer satisfaction. By definition, treatment acceptability refers to measures of acceptability completed by potential consumers of treatment procedures before they begin treatment. Alternatively, consumer satisfaction refers to satisfaction with treatment outcome after treatment completion. Therefore, consumer satisfaction measures are confounded by experience with the treatment whereas treatment acceptability measures are not. Consumer satisfaction measures completed after treatment termination give no indication of how the same program may have been evaluated prior to treatment; that is, by treatment acceptability measures. Furthermore, consumer satisfaction measures are typically completed only by subjects who complete treatment and not those who drop out or choose not to enter this type of treatment.

In the following section, current research on the treatment acceptability of interventions for child behavior problems will be reviewed. The review is divided into three segments. The first segment will describe the pioneering work by Alan E. Kazdin. The investigation of factors relating to teachers' judgements of acceptability of classroom interventions by Joseph C. Witt and his associates is then described. The third segment will describe various other research investigations of treatment acceptability.

Review of the Treatment Acceptability Literature

Kazdin's Research

Research concerned with treatment acceptability was inaugurated by Alan Kazdin in a series of studies investigating the acceptability of various interventions for child behavior problems (Kazdin, 1980a, 1980b, 1981, 1984; Kazdin, French, & Sherick, 1981). Kazdin has developed a standard methodology in which subjects are presented with an audiotaped case description of a child's problem and several (usually four) treatment procedures designed to alleviate the problem. A replicated Latin square design is employed to control for potential order and sequence effects of the interventions. Subjects are asked to evaluate each procedure by completing the Treatment Evaluation Inventory (TEI; Kazdin, 1980a) and by rating fifteen sets of bipolar adjectives representing the Evaluative, Potency, and Activity dimensions of the Semantic Differential (Osgood, Suci, & Tannenbaum, 1957).

Each subject is presented with a description of one of two children whose behavior warranted treatment. Age, gender, intelligence, and usually setting (Kazdin, 1980a, 1981, 1984; Kazdin et al., 1980) are varied to ensure that treatment evaluations are not restricted to these aspects of the description. In Kazdin's earlier studies (1980a, 1980b), both cases described highly disruptive and noncompliant behavior, likely classified as conduct disorder, while the later studies (Kazdin, 1981, 1984; Kazdin et al., 1981) described both conduct disorder and attention deficit disorder types of behavior.

The TEI consists of fifteen items in a Likert-like format which assesses whether the treatment is acceptable for the child's problem behavior; the willingness to carry out this procedure; the suitability of the procedure for the child; how likeable, fair, and humane the procedure is; and so on. Kazdin initially generated a pool of 45 items thought to be related to acceptability. Through a

series of pilot investigations, the inventory was reduced to fifteen items and factor analyzed to yield a solution in which all items produced high loadings on a single principal component before rotation (range from .67 to .94). After varimax rotation, factor loadings ranged from .61 to .95 on the first factor (Kazdin, 1980a). The TEI has been shown to differentiate among various interventions in terms of their relative acceptability (Kazdin, 1980a, 1980b, 1981; Kazdin et al., 1981).

Items on the Semantic Differential represent three dimensions: Evaluative (good-bad, kind-cruel), Potency (strong-weak, heavy-light), and Activity (active-passive, fast-slow). Kazdin has employed the Semantic Differential for two reasons. The Evaluative dimension represents an overall general evaluation of treatment while providing a methodologically distinct assessment device from the TEI. Second, the dimensions of Potency and Activity reflect different characteristics of treatment that may provide further information related to evaluations of treatment acceptability.

In assessing the varying acceptability of child treatment approaches, Kazdin has consistently found that subjects (undergraduate students, inpatient psychiatric children and their parents, hospital staff) have been able to distinguish between alternative treatments on the basis of acceptability (Kazdin, 1980a, 1980b, 1981, 1984; Kazdin et al., 1981). In these studies, positive reinforcement has been rated as the most acceptable treatment. For example, Kazdin (1981) found that undergraduate students rated positive reinforcement most acceptable, followed by positive practice, time out, and medication. Another study found that positive reinforcement was rated as more acceptable than various forms of time out (Kazdin, 1980b).

In addition to documenting the relative acceptability of various treatment interventions, Kazdin has assessed various parameters related to treatment

acceptability. He found that treatments were rated more acceptable when they were applied to more severe clinical problems (Kazdin, 1980a) and that acceptability of a procedure can be altered by changing the manner in which it is presented to the clients and implemented (Kazdin, 1980b). For example, variations of time out that do not completely remove the child from the situation were rated as more acceptable than was an isolation form of time out. Kazdin (1981) also demonstrated that the efficacy of a treatment was not related to acceptability, but undesirable side effects of treatment did decrease acceptability ratings.

These parametric studies are limited in their generalizability due to their exclusive reliance on undergraduate students as raters of acceptability. In two additional studies, Kazdin has had potential consumers complete the acceptability measures (Kazdin, 1984; Kazdin et al., 1981). In the 1981 study, inpatient psychiatric children, their parents, and hospital staff on the unit differentiated among alternative treatments on the basis of their acceptability. Reinforcement of incompatible behavior was rated as most acceptable followed by positive practice, medication, and time-out from reinforcement. Although the three groups of subjects rated the treatments in the same order, the children tended to rate the treatments as less acceptable than did their parents, with staff ratings falling between the two groups.

The second study (Kazdin, 1984) had inpatient psychiatric children and their parents rate three intervention alternatives: time-out from reinforcement, locked seclusion, and medication. Kazdin found that parents rated time-out from reinforcement as most acceptable while the children rated medication as most acceptable. Treatments that produced strong effects were rated as more acceptable by both groups than treatments that produced weak effects, in contrast to Kazdin's 1981 study with an analogue population.

Witt's Research

An extension of Kazdin's work has been initiated by Witt and his colleagues into the acceptability of behavioral interventions in the public school setting (Elliott, Witt, Galvin, & Peterson, 1984; Martens, Witt, Elliott, & Darveaux, 1985; Witt, Elliott, & Martens, 1984; Witt & Martens, 1983; Witt, Martens, & Elliott, 1984; Witt, Moe, Gutkin, & Andrews, 1984; Witt & Robbins, 1985). In contrast to Kazdin's methodology, Witt's general design consists of having subjects read one of several possible case descriptions depicting a problem behavior, and then evaluating the acceptability of one intervention designed to modify the behavior.

Since Witt uses a between-subjects design, multiple cases are created to operationalize all combinations of the independent variables. In all of the studies, Witt has varied the level of behavior problem severity. These levels were selected from earlier pilot work (Witt, Martens, & Elliott, 1984). For example, the lowest level of severity used was daydreaming while destruction of others' property ranked as the highest level of severity. In addition to varying level of behavior problem severity, Witt has investigated other parameters of intervention techniques and the interactions among the variables. Examples of parameters investigated are teacher time involvement, positive versus reductive interventions, intervention complexity, and teacher experience.

Treatment acceptability has been measured by the Intervention Rating Profile (IRP), a 20-item Likert-like scale developed to assess teachers' perceptions of the acceptability of classroom interventions (Witt & Martens, 1983). The IRP and its shorter form, the IRP-15 possess relatively good psychometric properties (Witt & Elliott, 1985). A principal components factor analysis with varimax rotation yielded one primary factor accounting for 41% of the variance (labeled as a general acceptability dimension) and four secondary factors described as the amount of risk

to the child; the amount of teacher time required for the intervention; the degree to which the intervention has negative effects on other children; and the amount of teacher skill required to implement the intervention. Using Cronbach's alpha, reliability was found to be .91. Using the IRP-15, items loaded on a single factor ranging from .82 to .95 which seems to reflect a general acceptability dimension. Reliability of the IRP-15 using Cronbach's alpha was found to be .98 (Martens et al., 1985).

In a series of studies, Witt and his associates have found that the acceptability of classroom interventions is mediated by many factors. For various behavior problems, interventions requiring high amounts of teacher time for planning and implementations were less acceptable than those requiring lesser amounts of time (Witt, Elliott, & Martens, 1984; Witt, Martens, & Elliott, 1984). However, lower levels of teacher time involvement were viewed as less acceptable for severe, as opposed to mild and moderate, behavior problems (Witt, Martens, & Elliott, 1984). Teacher acceptability ratings were found to vary significantly with the severity of the behavior problems (Martens et al., 1985; Witt, Elliott, & Martens, 1984; Witt, Moe, Gutkin, & Andrews, 1984). Interventions applied to more severe behavior problems have been rated as more acceptable than interventions applied to mild behavior problems (Martens et al., 1985; Witt & Robbins, 1985). Generally, positive or reinforcing interventions were judged as more acceptable than negative or reductive interventions (Elliott et al., 1984; Witt, Elliott, & Martens, 1984), thus extending Kazdin's findings to a different consumer population. Positive interventions were viewed as less risky than negative or reductive interventions (Witt, Elliott, & Martens, 1984). Highly experienced teachers generally rated interventions as less acceptable than teachers new to the profession (Witt & Robbins, 1985; Witt, Moe, Gutkin, & Andrews, 1984). Interventions implemented by

the teacher were rated as more acceptable than those implemented by someone else (Witt & Robbins, 1985). Interventions described in pragmatic language were evaluated as significantly more acceptable than interventions described in either behavioral or humanistic terms (Witt, Moe, Gutkin, & Andrews, 1984).

Other Treatment Acceptability Studies

Although Kazdin and Witt have been responsible for the proliferation of two distinct programs of research in treatment acceptability, other studies have appeared in the literature which address and extend this same research area while utilizing methodologies that depart from the standard formats employed by Kazdin and Witt.

Frentz and Kelley (1986) describe a study in which 82 nonclinic mothers of 2- to 12-year old children read one of two vignettes describing an 8-year old noncompliant and aggressive boy that varied only in behavior problem severity (mild versus severe). Using the TEI (Kazdin, 1980a), subjects rated five different reductive treatment methods (differential attention, response cost, time out, time out with spanking, spanking alone) which were presented in a randomized order following the case description. Additionally, mothers completed the Eyberg Child Behavior Inventory (Eyberg & Robinson, 1983; Eyberg & Ross, 1978; Robinson, Eyberg, & Ross, 1980) for their child. The Eyberg Child Behavior Inventory is a 36-item behavior problem checklist that has been shown to be a reliable and valid measure of conduct problems in children aged 2 to 16 years.

Frentz and Kelley (1986) found that response cost was rated significantly more acceptable than all other interventions. Time out was rated significantly more acceptable than differential attention, time out with spanking, and spanking alone, which were all rated in the unacceptable range of the TEI (i.e., 15-60). All treatments were perceived as more acceptable when applied to the severe behavior

problem description rather than the mild behavior problem description, with rank ordering of the interventions remaining the same. The authors hypothesized that parents who perceived their child as exhibiting behavior problems, as measured by the Eyberg Child Behavior Inventory and similar to scores obtained by clinic mothers, might differ in their acceptability ratings from parents who viewed their children as nonproblematic. This prediction was not supported.

Regular classroom elementary teachers rated the acceptability of four classroom treatment interventions (medication, time-out from reinforcement, positive practice, and reinforcement of incompatible behavior) in a study conducted by McKee (1984). Teachers were assigned to treatment conditions based on their score on a measure of knowledge of social learning principles (high versus low) and randomly assigned within knowledge groups to one of two case descriptions. Both cases described an aggressive, nonconcompliant 9 year-old boy. The second case varied only by the inclusion of additional information suggesting that the child had been in special education classes and was now being mainstreamed. Teachers in the high and low knowledge groups read the assigned case description and then rated the acceptability of the four treatments in a replicated Latin-square design. Treatment acceptability was measured by the TEI (Kazdin, 1980a), selected adjectives from the Semantic Differential (Osgood et al, 1957), and a questionnaire which in part asked subjects to rank order the treatments in terms of the likelihood of being used by the subject.

McKee (1984) found that high knowledge group teachers rated the four treatments as more acceptable than the low knowledge group teachers. The implication of such a finding is that one might increase the treatment acceptability of behavioral interventions by correspondingly increasing the rater's knowledge of behavioral principles. Reinforcement was rated as most acceptable, followed by

time out and positive practice, which did not differ from each other in terms of acceptability. Medication was rated as the least acceptable intervention. This sequence of differing acceptability is generally consistent with Kazdin's and Witt's findings. Acceptability ratings for the two cases were not found to be significantly different.

In a study conducted by Dorsett and Hobbs (1985), twenty parents of nonreferred children between the ages of 3 and 12 viewed a videotape of a mother implementing four different behavior management techniques (exclusionary time out, nonexclusionary time out, social reinforcement, and token reinforcement with praise) for her daughter's oppositional behavior. Half of the subjects viewed implementations that were "easy"; that is, the child cooperated with the application of the procedure and no adverse side effects were shown. The remaining parents evaluated "difficult" implementations in which the child cooperated less and adverse side effects were included, such as crying and escape behaviors in the time-out condition, arguing about when the back-up reinforcer would be delivered in the token reinforcement condition, and the child requesting to be left alone in the social reinforcement condition. Subjects evaluated each of the four techniques by completing the TEI (Kazdin, 1980a).

The results of this study lend further support for earlier findings of greater acceptability of reinforcement procedures relative to time-out procedures for child behavior problems. Social reinforcement was rated as most acceptable, followed by token reinforcement, nonexclusionary time out, and exclusionary time out. No significant statistical differences were found either between the two types of time out or the two types of reinforcement.

Contrary to Kazdin's (1981) findings that undesirable side effects of treatment decreased acceptability ratings, Dorsett and Hobbs found no significant differences

in TEI scores as a function of easy versus difficult implementations. The authors suggest several possible explanations for this disparity. First, the side effects presented by way of videotape may have been perceived as less severe than those described on audiotape by Kazdin (1981). Second, subjects in this study were likely given more information on the administration of these techniques and the appropriate handling of negative behaviors due to the method of presentation than the subjects in Kazdin's study. The authors speculate that treatments with adverse side effects may be evaluated more favourably if the model manages the negative behavior effectively. Finally, parental perceptions of adverse side effects and their subsequent ratings of treatment acceptability may differ substantially from those of undergraduate students used in Kazdin's (1981) study.

A study conducted by Norton, Austen, Allen, and Hilton (1983) compared ratings of intervention acceptability and effectiveness by teachers and parents of elementary school age children. Subjects read a description of a child who had been engaging in disruptive behaviors. Case descriptions were the same except for the sex of the child, the child's age (5 versus 10 years), and the grade level of the child (kindergarten versus fifth grade). Subjects were asked to rate five different discipline procedures that had been recommended by a professional. These were selective (differential) reinforcement, isolation time out, contingent observation, isolation with contractual agreement, and withdrawal of attention backed by isolation. Each procedure was evaluated by two items on a 5-point Likert-like scale. One item assessed acceptability while the other assessed effectiveness.

Norton et al. (1983) found that acceptability and perceived effectiveness for reducing disruptive behavior varied as a function of the treatment procedure, the rater of the procedure, and the age of the child for whom the procedure was

designed. Teachers evaluated all procedures as more effective than did parents. All of the procedures except reinforcement were perceived as being more effective for a younger child than an older child. Consistent with both Kazdin's and Witt's findings, positive reinforcement was rated by both teachers and parents as the most acceptable intervention.

Fincham and Spettell (1984) investigated the acceptability of operant Dry Bed Training (Azrin, Sneed, & Fox, 1974) and urine alarm training for the treatment of nocturnal enuresis in two experiments. In the first experiment, a consumer satisfaction study, parents and their enuretic children were randomly assigned to either the Dry Bed Training condition or the urine alarm training condition. Each group rehearsed the components of the procedure in the clinic and were given detailed treatment manuals. After the 8-week treatment program, participants completed a modified version of the TEI (Kazdin, 1980a; 1980b) and selected adjectives representing the Evaluative, Potency, and Activity dimensions of the Semantic Differential (Osgood et al., 1957). Parents in the urine alarm group rated the treatment more favourably than those in the Dry Bed Training group. However, as noted by Fincham and Spettell, the results may have been due to the relative effectiveness of the two treatments since three quarters of the children in the urine alarm group reached criterion as compared to less than half of the Dry Bed Training group.

In an attempt to eliminate this confound, undergraduate students evaluated the treatment acceptability of urine alarm training or Dry Bed Training, based on written descriptions of each procedure. In the descriptions, each intervention was administered by a professional or by parents who employed a self-help book. Professionally administered interventions were rated more favourably than the nonprofessionally administered interventions. Students perceived no difference in

treatment acceptability between the Dry Bed Training or urine alarm training. Based on these results, Fincham and Spettell (1984) interpreted the parents' preference for the urine alarm program in the first study to be a function of differential efficacy rather than differing acceptability prior to treatment. However, the use of undergraduate students as raters in the second study reduces the confidence that may be placed in this conclusion since students and parents may perceive the treatment acceptability of these programs differently.

Summary of the Treatment Acceptability Research

The reviewed studies have been well-designed in that they have utilized appropriate acceptability measures and evaluated several variables that influence acceptability ratings in a systematic fashion. However, the research is limited in its generalizability. For many studies, analogue population of undergraduate students have been utilized to evaluate treatment alternatives (Fincham & Spettell, 1984; Kazdin, 1980a, 1980b, 1981; Witt, Elliott, & Martens, 1984; Witt & Martens, 1983). At best, a student population can be thought of as potential future consumers since most of them are not parents, parents of children with behavior problems, or individuals who are likely to implement the intervention (i.e., teachers, hospital staff, clinicians).

Furthermore, the studies reviewed have examined the relative acceptability of various treatment techniques as entities rather than as components in a program of procedures designed to deal with various child behaviors. The behavioral treatment of child behavior problems such as conduct disorders or attention deficit disorders is not typically limited to one technique. Generally, a program of integrated procedures is recommended (e.g., Barkley, 1981; Forehand & McMahon, 1981; Patterson, 1982).

Parent Training Program

Noncompliance to parental instructions is recognized as a pervasive childhood problem among children referred to clinics for treatment of deviant behavior (Forehand, 1977). A parenting program specifically designed to treat child noncompliance has been developed by Forehand and McMahon (1981). The program is designed for parents of children in the 3- to 8-year old range. Sessions are conducted in a controlled learning environment with individual families. A number of specific parenting skills based on social learning principles are taught to the parents so that they may change their maladaptive patterns of interaction with their child. Therapists use didactic instruction, modeling, and role play to instruct the parent. The parent then practices the skills with his or her child while receiving prompts and feedback from the therapist. Finally, the parent utilizes the new skills in the home. Temporal and behavioral criteria determine progression to each new skill.

The parenting program has two phases. In the first phase, parents are taught to become more effective reinforcing agents by "increasing the frequency and range of social rewards and by reducing the frequency of competing verbal behavior." (McMahon & Forehand, 1984, p. 300). Three skills are taught in this phase: attends, rewards, and ignoring. Parents are taught to verbally describe and give attention to their child's appropriate behavior with attends. The parents are taught to use verbal and physical rewards (e.g., praise, hugs) contingent upon appropriate behavior and compliance with instructions. Parents are also taught to ignore minor inappropriate behavior.

Phase Two is concerned with decreasing child noncompliance to parental commands. Two skills are taught. First, parents learn to give appropriate commands. These are clear and direct, given one at a time, and allow the child

sufficient time to initiate compliance. If compliance is not initiated within 5 seconds, parents are taught to employ a time-out procedure.

The program has undergone extensive systematic research examining treatment outcome and generalization of effects (McMahon & Forehand, 1984). This program of research has indicated that improved mother and child behaviors generalize from the clinic training situation to the home setting. Maintenance of these positive gains in the home has been demonstrated at follow-up assessments ranging from 6 months to 4 1/2 years following the conclusion of treatment. Mothers have also been shown to generalize their skills to nontargeted children in the family without direct programming, resulting in increased compliance by the untreated child. The research suggests that generalization from treated to untreated child behaviors also occurs (McMahon & Forehand, 1984).

The social validity of this parent training program has been demonstrated by several methods. By way of social comparison, maternal and child behaviors as well as maternal personal adjustment (depression) have come within normal limits by the end of treatment (Forehand, Wells, & Griest, 1980). A second social validation procedure, subjective evaluation, has been conducted. Mothers that have recieved treatment have reported significant improvements in their children's behavior by the end of treatment. By a 2-month follow-up, these mothers also perceived their children to be as well-adjusted as nonclinic mothers perceived their children (Forehand et al., 1980).

Measures of consumer satisfaction with the program have been collected in several investigations. Mothers have "reported a high level of satisfaction with the overall training program, the therapists, the teaching format, and the parenting skills" (McMahon, Tiedemann, Forehand, & Griest, 1984, pp. 301-302) and generally maintained their high degree of satisfaction at a 2-month follow-up. A comparison

of mothers who received a technique-oriented version of the parenting program versus mothers who received the parenting program plus instruction in social learning principles found that mothers of the social learning group maintained their high levels of satisfaction with the parent training program at 2-month follow-up in a more consistent manner than did mothers of the technique alone group (McMahon et al., 1984). In a long-term follow-up, Baum and Forehand (1981) assessed consumer satisfaction from 1 to 4 1/2 years after treatment termination. At all follow-up periods, mothers expressed a high level of satisfaction with the treatment program. Forehand et al. (1980) found that mothers of clinic-referred children viewed the treatment procedures as appropriate for dealing with their children's problems at a 15-month follow-up assessment.

An aspect of social validity that has not been evaluated in the Forehand and McMahon parent training program is that of treatment acceptability. Consumer satisfaction measures completed after treatment termination give no indication of how the same program may have been evaluated prior to treatment and, as noted earlier, such ratings are possibly affected by the perceived efficacy of the different procedures. One of the purposes of the proposed investigation is to examine the acceptability of the various component skills in this parent training program.

Use of Rationales and Modeling in Parent Training Programs

Therapists in behavioral parent training programs teach parents operant techniques in order that the parents may modify their child's problem behavior in the child's natural environment (Tharp & Wetzel, 1969). Usually, parents are left to their own devices in introducing new behavior management techniques to the child. The child is often left to learn the new contingencies by trial and error since the parents employ the technique without demonstration or explanation. Traditional behavioral parent training programs have not typically made any attempts at identifying optimal methods for introducing the new behavioral techniques to the child.

However, in the developmental literature there is substantial data to suggest that verbal (instructions, rationales) and performance (modeling, behavior rehearsal) methods can enhance a child's comprehension and compliance to new contingencies (Davies, McMahon, Flessati, & Tiedemann, 1984). In another investigation, 100 mothers of young children (ages 3 to 6) completed a questionnaire in which they listed and evaluated strategies they employed with their children to elicit compliance and deal with noncompliance (McMahon et al., 1986). Lending further support for the use of verbal rationales, nearly all mothers (97.9%) reported that they frequently gave their child a rationale for a parental request. They evaluated this strategy as moderately acceptable for children of this age and as moderately useful and moderately easy to administer.

The utility of providing mediational techniques in a behavioral parent training program has only been recently demonstrated (Davies et al., 1984; McMahon, Davies, & Tiedemann, 1983). In the Davies et al. study, 80 mother-child pairs were randomly assigned to one of four groups: ignoring training, ignoring plus verbal rationale, ignoring plus verbal rationale and modeling, or control. In the treatment

groups, mothers were taught to ignore their child following noncompliance to maternal commands. It was found that when mothers provided a verbal rationale and/or modeled the procedure on a single occasion prior to its use, children were more compliant and less inappropriate than children in the other two conditions. Mothers in the rationale and rationale plus modeling groups reported greater satisfaction with the treatment than those mothers in the ignore only group.

A further investigation utilized the same methodology and extended it to the parenting technique of time-out from positive reinforcement (McMahon et al., 1983). Mothers were assigned to one of four groups: time out only, time out plus rationale, time out plus rationale and modeling, or control. The investigators found that all of the children in the treatment conditions were more compliant to maternal commands after their mothers' completion of training. The addition of a rationale or a rationale plus modeling did not increase compliance beyond time out only, possibly because of a ceiling effect. However, the behavior of the children in the two rationale groups was significantly less deviant than the behavior of the children in the time out only group. Mothers in all treatment conditions reported high levels of satisfaction with the procedures taught.

In the investigations just described, maternal ratings of consumer satisfaction may have been influenced by treatment efficacy. In the McMahon et al. study (1983) in which all children in the treatment groups were more compliant, mothers reported similar levels of satisfaction. In the Davies et al. study (1984), children in the mediation groups (rationale, rationale plus modeling) were more compliant and less inappropriate than children in the ignore only group. Correspondingly, mothers in the mediation groups reported greater satisfaction with treatment than mothers in the no mediation group. Since it has been demonstrated that providing a verbal rationale and/or modeling the procedure to the child enhances child behavior and

was also "high-ranking" by mothers in a survey (McMahon et al., 1986; Davies et al., 1984; McMahon et al., 1983), it is important to determine whether inclusion of a verbal rationale and/or modeling a new parenting technique to the child might also enhance parental evaluations of treatment acceptability.

Research Purposes and Hypotheses

The purposes of the present investigation were as follows:

1. To evaluate a well-validated parent training program, the Forehand-McMahon (1981) program, in terms of the treatment acceptability of its individual components and the overall program.

2. To evaluate the relative acceptability of having the parents provide their children with a verbal rationale, a verbal rationale plus modeling the procedure, or no rationale or modeling prior to use of the various parenting techniques.

3. To formally compare two treatment evaluation measures, that of the TEI (Kazdin, 1980a) and the usefulness/difficulty measures used by McMahon and Forehand in their consumer satisfaction investigations (Forehand & McMahon, 1981; McMahon et al., 1984).

It was hypothesized that:

1. Ratings of acceptability of the individual components, the mediational teaching method, and the overall program would fall within the positive range. Since scores on the TEI can range from 15 to 105, the positive range was defined as a score between 60 and 105.

2. While all parenting skills would be rated as acceptable, attends, rewards, and commands would be rated as more acceptable than ignoring and time out. The work of Kazdin and Witt (Elliott et al., 1984; Kazdin, 1980a; 1980b; 1981; Kazdin et al., 1981; Witt, Elliott, & Martens, 1984) has indicated that interventions designed to increase appropriate behavior are generally evaluated as more acceptable than interventions that attempt to decrease inappropriate behavior. As well, McMahon et al. (1986) found that praise for compliance and clear instructions (commands) were rated as more acceptable than time out and ignoring in their survey of nonclinic mothers. Finally, consumer satisfaction measures administered after

completion of the Forehand-McMahon parent training program have indicated that mothers view rewards as most useful and least difficult while ignoring is perceived to be one of the least useful and most difficult skills to implement (McMahon et al., 1984).

3. The individual techniques, the mediational teaching method, and the overall program within the rationale plus modeling condition will be evaluated more favourably than the individual techniques, the mediational teaching method, and the overall program within the rationale only condition, which will be evaluated more favourably than the individual techniques, the mediational teaching method, and the overall program within the technique alone condition.

4. A significant mediation by technique interaction will occur when relative levels of acceptability are assessed within each of the three conditions (rationale, rationale plus modeling, technique alone). Only in the technique alone group will there be a significant difference among the acceptability ratings of skills. That is, it is hypothesized that mediation (rationale or rationale plus modeling) will eliminate, or greatly reduce, the hypothesized disparity of acceptability ratings between procedures.

5. The TEI score will be positively correlated with the ratings of usefulness and negatively correlated with ratings of difficulty for each dependent measure.

Overview of the Investigation

Ninety nonclinic mothers of young (3- to 8-year old) children evaluated the overall parenting program, its individual components (attends, rewards, ignoring, commands, time out) and the method of introducing each new skill to the child (rationale, rationale plus modeling, no rationale or modeling). Nonclinic mothers were recruited since they represent potential consumers of the parent training program.

The measures employed to assess treatment acceptability were the Treatment Evaluation Inventory (TEI; Kazdin, 1980a) and the usefulness/difficulty measures of the Parent's Consumer Satisfaction Questionnaire (Forehand & McMahon, 1981). The Semantic Differential was not employed since it has not typically added any new information to that obtained by the TEI. The TEI was selected because it has relatively good psychometric properties (Kazdin, 1980a) and its use facilitated comparison between the outcome of Kazdin's work and this investigation. The usefulness/difficulty measure was added due to the similarity of the present investigation with investigations of consumer satisfaction for this particular parent training program (McMahon et al., 1984).

Mothers were randomly assigned to one of three mediation groups: parent training program only, parent training plus verbal rationale, or parent training plus verbal rationale and modeling. Mothers evaluated the program's individual components (attends, rewards, ignoring, commands, time out), the teaching method (verbal rationale, verbal rationale plus modeling, or no verbal rationale or modeling), and the overall parenting program. Therefore, the design was a 3 x 7 mixed factorial with repeated measures on the second factor.

Method

Subjects

Ninety mothers of children aged 3 to 8 served as subjects. This age range was chosen because it corresponds to the age range of children in the Forehand-McMahon parent training program. Subjects were recruited through notices published in city and community newspapers and notices posted in a variety of locations in the Lower Mainland, such as community centres, the University of British Columbia campus, libraries, and preschool centres (see Appendix A).

To be eligible to participate in this study, a potential subject had to be the mother of a 3- to 8-year old child and to have never sought psychological assistance for her child's behavior, never attended a structured, long-term parent training program (e.g., Systematic Training for Effective Parenting (Dinkmeyer & McKay, 1976); Parent Effectiveness Training (Gordon, 1975)), or previously been involved in research conducted at the University of British Columbia using the Forehand-McMahon parent training program. On this basis, seven subjects who completed the study were disqualified and replaced because of their involvement in a parent training program. Additionally, one subject was replaced due to the omission of too many items on the questionnaire. Seventeen mothers included in the study indicated that they had obtained some sort of psychological assistance for their child, which included a query on toilet training, school consultation, family counselling at time of marital separation, and short-term workshops or discussion groups on a variety of child-related issues. These subjects were included in the sample since the degree of "psychological assistance" was minimal or unrelated to the child's behavior. Mothers were paid \$5.00 for their participation in the project.

The modal number of children per family represented by this sample of mothers was two. Age of the subjects ranged from 21 to 54 years ($M=32.78, SD=5.54$), with no significant age differences among groups, $F(2,86)=.37, p=.695$. Seventy-six (84.4%) of the mothers were married or in long-term relationships while the remaining 14 mothers (15.6%) were either single, divorced, or separated. There were no significant differences among groups on marital status, $\chi^2(6, N=90)=7.94, n.s.$

Socioeconomic status for each subject was determined by coding the occupation of the major wage earner of the household according to the index developed by Blishen and McRoberts (1976). No significant difference in socioeconomic status was found among the three groups, $F(2,73)=1.27, n.s.$ Fulltime students and unemployed individuals were not included in the analysis since no code is designated for these categories in the Blishen and McRoberts system. This was not deemed problematic since each mediational group had an equivalent number of subjects falling into these categories (5, 5, and 4).

The educational level of mothers in this sample was as follows: 32.2% ($n=29$) had completed high school, 17.8% ($n=16$) had completed college, 32.2% ($n=29$) had completed university, and 17.8% ($n=16$) had completed graduate school. No significant differences in mothers' level of education across the three conditions was found, $\chi^2(6, N=90)=6.41, n.s.$

Design

The design was a 3 x 7 mixed factorial with one between-subjects factor with three levels (parent training only (P), parent training plus verbal rationale (PR), parent training plus verbal rationale and modeling (PRM)) and one within-subject variable with seven levels (attends, rewards, ignoring, commands, time out, mediational teaching method, overall program).

Dependent Measures

To evaluate the acceptability of the five parenting techniques, the method of introducing each new skill to the child, and the overall parent training program, the Treatment Evaluation Inventory (TEI; Kazdin, 1980a) (see Appendix B for an example of the TEI used to assess attends, the teaching method, and overall program, items 1 through 15) and the usefulness/difficulty ratings of the Parent's Consumer Satisfaction Questionnaire (PCSQ; Forehand & McMahon, 1981) (see Appendix B, items 16 and 17) were employed. For the purposes of this investigation, the wording of the TEI was modified slightly to reflect the three domains rated by the subjects (i.e., the skills, the method of introducing each new skill to the child, and the overall program). The TEI consists of 15 items in a Likert-like format on a 1- to 7-point scale. Subjects were asked to rate how acceptable treatment is, how willing they would be to carry out the procedure, how much they would like the procedure, and so on. As detailed previously, this measure has been shown to discriminate among various treatments on the basis of acceptability (e.g., Dorsett & Hobbs, 1985; Kazdin, 1980a, 1980b; McKee, 1984).

The usefulness/difficulty ratings of the PCSQ consist of two items which allow the subject to rate on 7-point scales the usefulness and difficulty of the procedures. These items discriminate between components differing in their subjective cost (difficulty) and perceived benefit (usefulness) (Yates, 1978). The PCSQ was developed to assess parental attitudes towards the treatment program parents received. The usefulness/difficulty ratings have been employed to evaluate the teaching methods of the program and parenting skills that are taught (attends, rewards, ignoring, commands, time out) (McMahon et al., 1984). The usefulness/difficulty ratings have also been shown to discriminate between mothers that have received training in the parenting techniques alone versus mothers that

have received additional training in social learning principles (McMahon, Forehand, & Griest, 1981; McMahon et al., 1984).

Procedure

Potential participants were told that the purpose of the project was to have mothers of young children evaluate the acceptability of a parent training program designed to teach parents ways to deal with their children's misbehavior and to improve the parent-child relationship by having them read about the various components of the program and completing some questionnaires. Subjects were told that the study would take approximately 60 minutes to complete and that they would be paid \$5.00 for their participation. If the mother agreed to participate and met the criteria for inclusion, a convenient time and place was established either at their home or at a laboratory in the Department of Psychology at the University of British Columbia.

Administration of the procedure occurred individually or in small groups. Subjects first completed a consent form which explained the purpose of the study and its procedures (see Appendix C) and a demographic information form (see Appendix D). Subjects were then randomly assigned to one of three groups by way of the packet of written materials they received. Subjects proceeded at their own pace since all instructions were contained within the packet. The packet consisted of: 1) a description of the typical child and family for whom the parent training program is designed and a rationale of the parent training program; 2) overview for Phase I; 3) description of attends; 4) evaluation of attends; 5) description of rewards; 6) evaluation of rewards; 7) description of ignoring; 8) evaluation of ignoring; 9) overview for Phase II; 10) description of commands (called "clear instructions" in the packet); 11) evaluation of commands; 12) description of time out; 13) evaluation of time out; 14) summary of the teaching method; 15) evaluation

of the teaching method; 16) summary of the overall program; and 17) evaluation of the overall program. The order and sequence of the techniques were not counterbalanced because in the context of the parent training program, the progression and sequence of various skills is fixed (Forehand & McMahon, 1981).

The descriptions of the various parenting skills and how they are introduced to the child (items 1, 3, 5, 7, 10, 12, 14, 16 from the above listing) varied for each of the three groups (see Appendix E):

Parent training only (P): The technique was described to the parent, but a rationale and demonstration were not given to the child.

Parent training plus verbal rationale (PR): The technique was described to the parent and the parent gave a rationale to the child prior to its use.

Parent training plus verbal rationale and modeling (PRM): In addition to giving a rationale, the parent demonstrated to the child how the technique would be used.

Scoring

Subjects responded to the 15 items on the TEI and the two additional usefulness/difficulty items by checking one position on the 7-point scale that most closely represented the subject's response to the described technique. For the purpose of scoring, each of the seven points was assigned a numerical value, where a value of one was assigned to the negative anchor point (e.g., not at all acceptable), a value of four represented a neutral position (e.g., moderately acceptable), and a value of seven was assigned to the positive anchor point (e.g., very acceptable). For the 15-item TEI, a total acceptability score could range from a minimum of 15 to a maximum of 105. Scores for each of the three measures (TEI, usefulness, difficulty) on each of the seven questionnaires were verified by a blind assessor and fewer than one percent errors in coding and scoring were found.

All scoring errors were corrected prior to analyses by agreement of the two coders.

Missing items were prorated by assigning the mean item score for that particular TEI measure to the missing item. (No missing data points were found on the usefulness/difficulty ratings.) Six subjects missed a total of 31 data points. Overall, this represents less than .004% of the total number of data points.

Results

Measures of Acceptability

As predicted, the individual components, the mediational teaching method, and the overall Forehand-McMahon parent training program were all rated in the positive range (60-105) on the TEI. The mean ratings are reported in Table 1. Of the five skills described, subjects rated rewards as most acceptable, ($\underline{M}$ =94.67, $\underline{SD}$ =11.02), followed by commands ($\underline{M}$ =94.06, $\underline{SD}$ =9.94), attends ($\underline{M}$ =88.69, $\underline{SD}$ =12.44), time out ($\underline{M}$ =83.23, $\underline{SD}$ =18.43), and ignoring ($\underline{M}$ =75.11, $\underline{SD}$ =19.89). With the exception of ignoring, all techniques were rated in the upper half of the positive range (82.5-105) while ignoring was rated in the lower half of the positive range (60-82.5). Subjects in this sample also rated the mediational teaching method ($\underline{M}$ =88.20, $\underline{SD}$ =13.54) and the overall Forehand-McMahon parent training program very positively ($\underline{M}$ =89.59, $\underline{SD}$ =13.87).

Table 1 also presents the mean acceptability scores separated by group (P, PR, PRM) for each of the five parenting skills, the mediational teaching method, and the overall program. Despite differences in acceptability between groups (to be presented below), again the five parenting skills, the mediational teaching methods, and the overall parent training program were rated in the positive range. With the exception of ignoring in all three groups, and time out in groups P and PRM, all parenting skills, the teaching methods, and the overall program were rated in the upper half of the positive range (i.e., 82.5-105).

A repeated measures analysis of variance with one between-subjects factor with three levels (Mediational Group: parent training only, parent training plus verbal rationale, parent training plus verbal rationale and modeling) and one within-subjects factor with five levels (Technique: attends, rewards, ignoring, commands, time out) was performed on the acceptability data provided by the TEI

Table 1

Mean TEI Ratings

Parenting Program	Group			Marginal Mean ^b
	P ^a	PR ^a	PRM ^a	
Attends	90.40 (8.98)	91.77 (10.46)	83.90 (15.76)	88.69 (12.44)
Rewards	96.23 (6.79)	98.10 (5.86)	86.67 (15.87)	94.67 (11.02)
Ignoring	73.73 (18.46)	81.77 (16.69)	69.83 (22.75)	75.11 (19.89)
Commands	93.23 (8.84)	95.17 (11.78)	93.77 (9.17)	94.06 (9.94)
Time out	81.83 (14.07)	89.30 (16.39)	78.57 (22.66)	83.23 (18.43)
Teaching method	86.00 (13.47)	93.87 (9.61)	84.73 (15.44)	88.20 (13.54)
Overall program	90.80 (7.85)	95.23 (7.98)	82.73 (19.55)	89.59 (13.87)

Note. P=parent training only; PR=parent training plus verbal rationale; PRM=parent training plus verbal rationale and modeling. Numbers in parentheses are standard deviations.

^a_n=30.

^b_N=90.

scores. The analysis yielded a significant main effect for mediational group, $F(2,87)=4.15$, $p=.019$, and a significant main effect for technique, $F(4,348)=50.70$, $p<.001$. The predicted mediational group by technique interaction was not found to be significant, $F(8,348)=1.53$, n.s. (see Appendix F).

Follow-up analyses of the main effect for mediational group by Newman-Keuls procedures indicated no significant differences between groups. However, visual inspection of Figure 1 suggests that much of the differences between groups can be accounted for by the difference between group PRM ($M=83.15$) and PR ($M=91.22$) while the differences between the means of PRM and P ($M=87.09$), and P and PR appear equivalent.

Newman-Keuls tests were performed to evaluate the sources of differences among ratings of the five parenting techniques (see Appendix G) and indicated that rewards ($M=94.67$) and commands ($M=94.06$) (which were not rated significantly different from each other) were rated as significantly more acceptable than attends ($M=88.69$), time out ($M=83.23$), and ignoring ($M=75.11$), each of which was rated as significantly different from one another ($p<.01$).

The a priori hypothesis that attends, rewards, and commands ($M=92.47$) would be rated as more acceptable than ignoring and time out ($M=79.17$) was confirmed by a test of planned comparisons, $t(85)=12.74$, $p<.01$.

A one-way analysis of variance was performed to analyze the treatment acceptability data for the mediational teaching method (see Appendix F). Results indicated significant differences between mediational groups, $F(2,87)=4.30$, $p=.017$. Newman-Keuls multiple comparison procedures were performed to evaluate differences among the three groups. As seen in Appendix H, PR ($M=93.87$) was rated as significantly more acceptable than P ($M=86.00$) and PRM ($M=84.73$), which did not differ from each other ($p<.05$).

Figure Caption

Figure 1. Mean TEI score for each mediational group collapsed across techniques.

(P=parent training only; PR=parent training plus verbal rationale;

PRM=parent training plus verbal rationale and modeling; n=30 per group).

Treatment acceptability ratings for the overall program were analyzed by way of a one-way analysis of variance (see Appendix F). The effect of the mediational group was statistically significant, $F(2,87)=7.12$, $p<.002$. Follow-up Newman-Keuls multiple comparison procedures indicated that PR ($M=95.23$) and P ($M=90.80$) were not rated significantly different from each other but both were rated as significantly more acceptable than PRM ($M=82.73$) (see Appendix H).

Usefulness/Difficulty Measures

Evaluations of the usefulness of the individual techniques, the teaching method, and the overall program were all in the "useful" range of the 7-point Likert-like rating scale and are reported in Table 2. The ordering of means for the five parenting skills beginning with the most useful consisted of commands ($M=6.27$, $SD=.91$), rewards ($M=6.14$, $SD=1.12$), attends ($M=5.96$, $SD=1.22$), time out ($M=5.80$, $SD=1.29$), and ignoring ($M=5.30$, $SD=1.46$). Both the teaching method ($M=5.98$, $SD=1.06$) and the overall program ($M=6.17$, $SD=1.00$) were rated as very useful.

With the exception of ignoring, mean ratings of difficulty fell in the "easy" range of the 7-point scale for the individual techniques, the teaching method, and the overall program (see Table 3). The ordering of means for the five parenting skills beginning with the easiest consisted of rewards ($M=2.54$, $SD=1.54$), commands ($M=2.98$, $SD=1.74$), attends ($M=3.11$, $SD=1.76$), time out ($M=3.60$, $SD=1.88$), and ignoring ($M=4.19$, $SD=1.95$). Both the teaching method ($M=3.20$, $SD=1.63$) and the overall program ($M=3.46$, $SD=1.57$) were rated in the "easy" range by subjects in this sample.

Separate 3 x 5 repeated measures analyses of variance with one between-subjects factor (Mediational Group: parent training only, parent training plus verbal rationale, parent training plus verbal rationale and modeling) and one within-subjects factor (Technique: attends, rewards, ignoring, commands, time out)

Table 2

Mean Ratings of Perceived Usefulness

Parenting Program	Group			Marginal Mean ^b
	P ^a	PR ^a	PRM ^a	
Attends	5.93 (1.11)	6.17 (1.05)	5.77 (1.46)	5.96 (1.22)
Rewards	6.00 (1.31)	6.33 (.55)	6.10 (1.32)	6.14 (1.12)
Ignoring	5.03 (1.45)	5.60 (1.16)	5.27 (1.70)	5.30 (1.46)
Commands	6.17 (.83)	6.23 (1.07)	6.40 (.81)	6.27 (.91)
Time out	5.57 (1.36)	6.07 (1.17)	5.77 (1.33)	5.80 (1.29)
Teaching method	5.80 (1.00)	6.13 (1.04)	6.00 (1.15)	5.98 (1.06)
Overall program	6.03 (.85)	6.43 (.73)	6.03 (1.30)	6.17 (1.00)

Note. P=parent training only; PR=parent training plus verbal rationale; PRM=parent training plus verbal rationale and modeling. Rating scale anchors: extremely useless=1, neutral=4, extremely useful=7. Numbers in parentheses are standard deviations.

^a_n=30.

^b_N=90.

Table 3

Mean Ratings of Perceived Difficulty

Parenting Program	Group			Marginal Mean ^b
	P ^a	PR ^a	PRM ^a	
Attends	3.07 (1.68)	2.60 (1.45)	3.67 (2.01)	3.11 (1.76)
Rewards	2.30 (1.47)	2.27 (1.36)	3.07 (1.68)	2.54 (1.54)
Ignoring	4.13 (1.70)	4.07 (2.13)	4.37 (2.04)	4.19 (1.95)
Commands	3.03 (1.65)	2.40 (1.30)	3.50 (2.06)	2.98 (1.74)
Time out	3.90 (1.75)	2.93 (1.55)	3.97 (2.17)	3.60 (1.88)
Teaching method	3.27 (1.46)	2.73 (1.39)	3.60 (1.92)	3.20 (1.63)
Overall program	3.67 (1.35)	3.00 (1.37)	3.70 (1.90)	3.46 (1.57)

Note. P=parent training only; PR=parent training plus verbal rationale; PRM=parent training plus verbal rationale and modeling. Rating scale anchors: extremely easy=1, neutral=4, extremely difficult=7. Numbers in parentheses are standard deviations.

^a_n=30.

^b_N=90.

were conducted for both the usefulness and difficulty ratings. With respect to the usefulness ratings, a significant main effect of technique was found, $F(4,348)=12.59$, $p<.01$. Neither a main effect of mediational group, $F(2,87)=1.35$, n.s., nor a mediational group by technique interaction, $F(8,348)=.59$, n.s., was found (see Appendix I). Newman-Keuls tests to evaluate the differences between techniques indicated that ignoring ($M=5.30$) was rated as significantly less useful than all other techniques while time out ($M=5.80$) was rated significantly less useful than commands ($M=6.27$) (see Appendix G).

Regarding the analysis of variance conducted on ratings of difficulty, both a main effect of group, $F(2,87)=3.78$, $p<.027$, and technique, $F(4,348)=17.70$, $p<.01$, were found. No significant group by technique interaction was found, $F(8,348)=.85$, n.s. (see Appendix J). Despite the statistically significant omnibus F , no significant differences among groups were detected by follow-up Newman-Keuls procedures. Visual inspection of Figure 2 suggests that a large portion of the differences between groups would be accounted for by the difference between groups PRM ($M=3.71$) and P ($M=3.29$), while the differences between groups PR ($M=2.85$) and P, and P and PRM appear equivalent.

Newman-Keuls tests were performed to evaluate the sources of differences among ratings of difficulty of the five parenting techniques (see Appendix G). Ignoring ($M=4.19$) was rated as significantly more difficult than all other parenting techniques. Time out ($M=3.60$) was rated as significantly more difficult than rewards ($M=2.54$), commands ($M=2.98$), and attends ($M=3.11$). Commands and attends did not differ from each other but both were rated significantly more difficult than rewards.

Four separate one-way analyses of variance were conducted on the usefulness and difficulty ratings for the teaching method and overall program. No significant

Figure Caption

Figure 2. Mean ratings of difficulty for each mediational group collapsed across techniques.
(P=parent training only; PR=parent training plus verbal rationale; PRM=parent training plus verbal rationale and modeling; n=30 per group.)

differences among mediational groups were found either for the teaching method or overall program on measures of usefulness (see Appendix I) or difficulty (see Appendix J).

Relationship Between Usefulness/Difficulty Ratings and Ratings of Acceptability

Pearson correlation coefficients were calculated for the relationships between TEI score and ratings of usefulness, and TEI score and rating of difficulty for each of the seven measures (attends, rewards, ignoring, commands, time out, teaching method, overall program) (see Table 4). Usefulness ratings for each of the seven dependent measures were positively correlated with the corresponding TEI scores, ranging from $r=.606$ (rewards) to $r=.816$ (ignoring). In order to control for inflation of Type I error, the alpha level was reduced to .007 (.05/7). All correlations between TEI and usefulness ratings were significant (see Table 4). All of the difficulty ratings were negatively correlated with TEI scores ranging from $r=-.139$ (rewards) to $r=-.342$ (teaching method). With the exception of rewards, all correlations were significant at the $p<.007$ level (see Table 4).

In order to summarize the data, each subject's seven TEI scores, seven usefulness scores, and seven difficulty scores were totalled to obtain three summary TEI, usefulness, and difficulty scores. Correlations among these measures indicated a strong positive correlation between usefulness ratings and the TEI ($r=.802$, $p<.001$), a negative correlation between difficulty ratings and the TEI ($r=-.390$, $p<.001$), and a negative correlation between usefulness and difficulty ratings ($r=-.280$, $p<.01$).

Table 4

Intercorrelations Between TEI and Usefulness and Difficulty Ratings

TEI	Usefulness	Difficulty
Attends	.794*	-.268*
Rewards	.606*	-.139
Ignoring	.816*	-.299*
Commands	.667*	-.283*
Time out	.798*	-.263*
Teaching method	.656*	-.342*
Overall program	.700*	-.314*

Note. N=90.

*p<.007.

Discussion

This study evaluated the treatment acceptability of a behavioral parent training program in terms of its individual techniques, three teaching methods, and the program as an entity. A sample of potential consumers of treatment composed of 90 nonclinic mothers of 3- to 8-year old children rated their acceptance of each parenting skill, the mediational teaching method, and the overall parent training program by way of a standardized measure of treatment acceptability (TEI; Kazdin, 1980a) and ratings of usefulness and difficulty previously employed in evaluations of consumer satisfaction (Forehand & McMahon, 1981; McMahon et al., 1984).

Major findings of this study will be addressed in terms of the acceptability, usefulness, and difficulty of the parenting skills, teaching methods, and overall program; the differential acceptability of the parenting skills; the differential acceptability of the teaching methods; the relationship between the teaching method and parenting skills; and the relationship between ratings of acceptability and usefulness/difficulty. Finally, conclusions and recommendations for future research will be discussed.

Hypothesis 1 proposed that the individual components, the teaching methods, and the overall Forehand-McMahon parent training program would be rated very positively on the TEI. This hypothesis was supported in that mothers in this sample found the individual parenting techniques, the teaching methods, and overall program to be appropriate for the problem described, fair, sensible, effective, and concurring with common ideas of what treatment should be. This finding lends further support to the social validity of the Forehand-McMahon parent training program.

Ratings of acceptability as measured by the TEI have previously been reported for specific behavioral procedures such as reinforcement (Dorsett & Hobbs, 1985;

Kazdin, 1980a, 1980b, 1981; Kazdin et al., 1981; McKee, 1984), ignoring (withdrawal of attention; Kazdin, 1980b), and time out (Dorsett & Hobbs, 1985; Frentz & Kelley, 1986; Kazdin, 1980a, 1980b, 1981, 1984; Kazdin et al., 1981; McKee, 1984). It is of interest to note that in all cases, the techniques of the Forehand-McMahon program were rated as more acceptable than those reported in the literature (except Kazdin, 1984, in which time-out from reinforcement ($M=83.50$) was equivalent to ratings of time out in this study ($M=83.23$)). While many variations between this study and those cited must be acknowledged (e.g., differences in the case description, technique specifications, and sample), an important difference which may account for higher ratings of acceptability of the Forehand-McMahon techniques is that they were described as part of an integrated program of procedures designed to deal with the child's behavior rather than as single isolated techniques.

With respect to the usefulness/difficulty ratings, the individual components, the teaching methods, and overall parent training program were rated as very useful on ratings of usefulness and with one exception, as easy on ratings of difficulty by mothers in this study. Only ignoring was rated as neutral on the difficulty dimension.

It is of interest to compare these ratings with those of actual consumers of the Forehand-McMahon parent training program and with nonclinic mothers rating their own parenting strategies. These comparisons highlight the influence of experience on such evaluations. The potential consumers of treatment in the present study read about the rationale for the program, the typical family for whom it is appropriate, and its individual skills while actual consumers have had the advantage of direct "hands-on" experience with the program and its components. Subjects in the current study consistently evaluated the individual techniques of

the parent training program as less useful and more difficult than actual consumers of this treatment program at post-treatment (cf. McMahon et al., 1984). Although the samples in these investigations likely vary in other dimensions in addition to whether they are potential or actual consumers (e.g., nonreferred mothers of "normal" children versus mothers referred for treatment of child noncompliance), this comparison suggests that direct experience with the actual treatment program may improve satisfaction in terms of perceived usefulness and difficulty.

Comparisons of ratings made by mothers in this study and nonclinic mothers who rated their own naturally-occurring parental strategies for child compliance (McMahon et al., 1986) again suggests that experience may influence ratings of usefulness and difficulty. Nonclinic mothers who had experience with the techniques but who had not participated in a systematic parent training program rated clear instructions (commands), time out, and ignoring as less useful than did the mothers in the present study, while praise for compliance (rewards) was rated as more useful. For ratings of difficulty, mothers with experience using the techniques (McMahon et al., 1986) rated praise for compliance (rewards), clear instructions (commands), and ignoring as easier and only time out as more difficult than the mothers in the present study.

The foregoing comparisons suggest that experience influences satisfaction with the various strategies. However, this influence is not consistent since actual consumers of the treatment program rated the techniques as more useful and less difficult (McMahon et al., 1984) than potential consumers, whereas mothers rating their own naturally-occurring strategies varied from this pattern (McMahon et al., 1986). This inconsistency may be due to the manner in which the mothers were taught the parenting skills or their subsequent employment of those skills, or it may be a function of differences between clinic and nonclinic mothers.

In support of Hypothesis 2, which proposed that the parenting skills would be differentially acceptable, interventions of this program that attempt to increase deficit behavior (rewards, commands, attends) were evaluated as more acceptable than the interventions designed to reduce behavioral excesses (time out, ignoring). This finding is also consistent with previous research in treatment acceptability (Dorsett & Hobbs, 1985; Elliott et al., 1984; Kazdin, 1980a, 1980b, 1981; Kazdin et al., 1981; Witt, Elliott, & Martens, 1984).

This ordering of techniques from most acceptable to least acceptable (rewards, commands, attends, time out, ignoring) directly parallels that of ratings of nonclinic mothers' naturally occurring parental strategies (McMahon et al., 1986), although attends were not rated by mothers in the McMahon et al. (1986) study. This differential acceptability of techniques based on whether they increase deficit behavior or reduce excessive behavior has also been validated in consumer satisfaction studies (McMahon et al., 1984).

The ordering of techniques from most acceptable to least acceptable directly corresponds to their ordering of usefulness and difficulty, with the exception of the reversal of commands and rewards on usefulness. Techniques designed to increase deficit behavior were rated as most acceptable, most useful, and least difficult while techniques designed to decrease behavioral excesses were rated as least acceptable, least useful, and most difficult.

Hypothesis 3 proposed that presenting a rationale and modeling each new skill to the child would be rated as more acceptable than presenting a rationale, which would be rated as more acceptable than no rationale or modeling. In the three descriptive analyses of parenting skills, mediational teaching method, and overall program, the rationale condition was rated as more acceptable than the technique alone condition, which was rated as more acceptable than the rationale plus

modeling condition. The analysis of teaching method provided the most direct assessment of the mediational group since subjects evaluated only the method of introducing new parenting skills to the child. In that analysis, the rationale condition was rated as significantly more acceptable than the remaining conditions, which did not differ from each other. Thus, Hypothesis 3 was not supported. With few exceptions, the greatest variability in all ratings was found in the rationale plus modeling group. This suggests that subjects in this group were in far less agreement in their evaluations than subjects in the remaining groups. Why this occurred is unclear but suggests that for some consumers, the addition of a modeling component detracts from the acceptability of the skills and the program.

Two studies have examined the utility of providing mediational techniques for introducing new parenting techniques to the child (Davies et al., 1984; McMahon et al., 1983). Both studies compared the introduction of ignoring (Davies et al., 1984) or time out (McMahon et al., 1983) by way of providing a verbal rationale, providing a verbal rationale and modeling the procedure, or no rationale or modeling. In terms of consumer satisfaction, the Davies et al. (1984) study found that mothers in the rationale and rationale plus modeling conditions expressed higher satisfaction with the skill than mothers who presented the technique without these adjuncts. No difference in satisfaction was found between the two mediational groups. The present study found only a superiority of the rationale condition, with no difference between the remaining two conditions. In the McMahon et al. (1983) study, mothers in all three groups expressed similar levels of satisfaction with the parenting technique (time out). However, the influence of experience, in this case a ceiling effect of high child compliance to maternal commands due to the efficacy of the time-out procedure, again emphasizes the contrast between treatment acceptability and consumer satisfaction.

Several explanations are possible for the greater acceptability of the rationale condition. First subjects in this study based their evaluations on the written descriptions provided. Descriptions were identical for all groups except that additional descriptions were appended to describe how rationales were employed and to describe how the technique would be modeled to the child. Consequently, the rationale plus modeling descriptions were quite lengthy and may have been perceived by raters as inordinately time consuming. Had this study employed videotaped instead of written demonstrations, the results may have been as hypothesized and consistent with previous research, since the addition of modeling is not as time consuming as it might appear when verbally described.

In addition to being perceived as time consuming, the rationale plus modeling condition might also have been perceived as more difficult to employ. Though not statistically significant, the rationale plus modeling condition was consistently rated as more difficult than the other two groups in the analyses of teaching method and overall program. Also, the analysis of difficulty ratings for the parenting techniques suggested that much of the differences between groups could be accounted for by the difference between the rationale and rationale plus modeling conditions. This suggests that in rating the individual skills, subjects perceived that it was easy to explain the new skill to the child, but the addition of modeling was perceived as more difficult.

Finally, subjects in the rationale plus modeling condition may have judged that the addition of modeling may have been too complex and unnecessary for the age group and type of child behavior problem for whom this program is designed. Further research is needed to determine whether these or other unknown factors account for the lower ratings given to the rationale plus modeling mediational procedure.

Differential ratings of acceptability of the parenting skills remained consistent across the three mediational groups, thus failing to support Hypothesis 4, which proposed that mediation (either rationale or rationale plus modeling) would reduce the disparity of acceptability between techniques. As well, there were no interactions between the mediational teaching method and techniques on ratings of usefulness and difficulty. While teaching method influenced the relative ratings of acceptability across groups, it did not reduce acceptability ratings across techniques within groups.

It would appear then that even having a very acceptable method of introducing each new parenting skill to the child does not affect the differential acceptability of the techniques. Techniques that are designed to increase deficit behavior will continue to be perceived as that much more acceptable than techniques designed to reduce excess behavior unless, as Kazdin demonstrated with variations of isolation (1980b), the actual techniques are modified so as to make them more acceptable to the potential consumer.

Due to the limitations of the methodology employed, however, it is possible that the written descriptions were not able to portray as vividly the various teaching methods, individual parenting skills, and how they would be employed in a comprehensive treatment program. Again, it might be useful to utilize videotaped demonstrations that would approximate actual clinical use of these mediational procedures more realistically.

With respect to the relationship between ratings of acceptability and usefulness/difficulty, ratings of treatment acceptability were positively correlated with ratings of usefulness and negatively correlated with ratings of difficulty, supporting Hypothesis 5. The ordering of techniques on usefulness and difficulty dimensions paralleled ratings of acceptability with the exception that the ordering

of commands and rewards was reversed with respect to usefulness. Generally, the most acceptable technique was also rated as the most useful and least difficult technique.

It was not unexpected that ratings of treatment acceptability and ratings of usefulness were strongly correlated. Items on the TEI address effectiveness, acceptability, fairness, likeability, and suitability that in many ways are captured in the benefits or "usefulness" of the technique. Similarly, the costs or "difficulty" of the technique are assessed in items that address fairness, risks, and discomforts associated with the technique.

These two single-item ratings of usefulness and difficulty produced very similar patterns to that of the TEI, which by Kazdin's report (1980a) captures an overall evaluative component. This suggests that these simplified scales have the potential to provide a quick assessment of treatment acceptability and thereby insure the cooperation of the raters. However, while these single-item ratings were able to differentiate among techniques, they were not as sensitive as the TEI in detecting potential differences among the three teaching methods.

Several conclusions and recommendations can be made from the present investigation. First, this study lends further support to the social validity of the Forehand-McMahon parent training program. The social validity of the parent training program has been previously demonstrated by social comparison, subject evaluation, and consumer satisfaction methods. These three social validation procedures are based on clients' actual experience with the intervention rather than an evaluation of treatment procedures by potential consumers before treatment begins. By assessing treatment acceptability, the three types of social validity described by Wolf (1978) have been addressed. Taken together, the social validity research suggests that the teaching methods employed in this program, the specific

parenting skills, and the overall program are generally viewed as very acceptable and appropriate by potential and actual consumers alike.

Second, unlike previous treatment acceptability research that has examined single, isolated treatment procedures, this study attempted to examine a comprehensive program of integrated procedures designed to deal with a particular child behavior problem, which would be the more typical approach taken by family therapists. Comparisons with previous research suggests that techniques within a program may be perceived as more acceptable than techniques presented separately, but this issue must be addressed further by systematic and controlled research.

Third, this study directly assessed the relative acceptability of three methods of introducing new parenting skills to a child. Presenting a verbal rationale was viewed as more acceptable than either presenting no rationale or presenting a rationale and modeling its use. Further research is required to determine the factors accounting for the perceived superiority of this mediational technique. The use of stimuli that portray the mediational techniques in a more comprehensive fashion (e.g., videotaped demonstrations) appears warranted.

Finally, a comparison of the results of this study with results of consumer satisfaction studies of the same parent training program indicate the important role of experience in the evaluation of treatment. Comparisons between potential and actual consumers of this treatment program suggest that potential consumers may be conservative in their estimates of usefulness and difficulty but are similar to actual consumers in distinguishing between techniques that decrease excess behavior versus those that increase deficit behavior. Additional research is needed in order to compare ratings of treatment acceptability with consumer satisfaction for individuals before, during, and after treatment intervention. This research may identify specific factors that influence changes in treatment evaluation and its

relationship to treatment outcome and produce a better theoretical understanding of the therapeutic process.

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Appendix A

Notice

Mothers of children between the ages of 3 and 8 are required for a research project associated with the Department of Psychology of the University of British Columbia. The project involves evaluating a program that teaches parenting skills. Approximately 60 minutes are required and \$5.00 will be paid for your participation. For additional information, contact Susan Cross Calvert, Clinical Psychology, University of British Columbia, 321-4346.

Appendix B

Please complete the items listed below. The items should be completed by placing a checkmark on the line under the question that best indicates how you feel about ATTENDS. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended. REMEMBER, EVALUATE THIS PARENTING SKILL AS IF YOU WERE THE PARENT OF A CHILD IN THE FAMILY SITUATION DESCRIBED EARLIER.

1. How acceptable do you find this procedure to be for the child's problem behavior?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable

2. How willing would you be to carry out this procedure yourself if you had to change the child's problems?

_____	_____	_____	_____
not at all		moderately	very
willing		willing	willing

3. How suitable is this procedure for children who might have other behavioral problems than those described for this child?

_____	_____	_____	_____
not at all		moderately	very
suitable		suitable	suitable

4. If children had to be assigned to this program without their consent, how bad would it be to give them this procedure?

_____	_____	_____	_____
very bad		moderately	not bad
		bad	at all

5. How cruel or unfair do you find this procedure?

_____	_____	_____	_____
very cruel		moderately	not cruel
		cruel	at all

6. Would it be acceptable to apply this procedure to institutionalized children, the mentally retarded, or other individuals who are not given an opportunity to choose treatment for themselves?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable
to apply this			to apply
procedure			this procedure

7. How consistent is this procedure with common sense or everyday notions about what a treatment should be?

very different or inconsistent	moderately consistent	very consistent with everyday notions
--------------------------------------	--------------------------	--

8. To what extent does this procedure treat the child humanely?

does not treat humanely at all	treats them moderately humanely	treats them very humanely
---	---------------------------------------	---------------------------------

9. To what extent do you think there might be risks in undergoing this kind of procedure?

lots of risks are likely	some risks are likely	no risks are likely
-----------------------------	--------------------------	------------------------

10. How much do you like the procedure?

do not like it at all	moderately like it	like it very much
--------------------------	-----------------------	----------------------

11. How effective is this procedure likely to be?

not at all effective	moderately effective	very effective
-------------------------	-------------------------	-------------------

12. How likely is this procedure to make permanent improvements in the child?

unlikely	moderately likely	very likely
----------	----------------------	----------------

13. To what extent are undesirable side effects likely to result from this procedure?

many undesirable side effects likely	some undesirable side effects likely	no undesirable side effects would occur
---	---	--

14. How much discomfort is the child likely to experience during the procedure?

very much discomfort	moderate discomfort	no discomfort at all
-------------------------	------------------------	----------------------------

15. Overall, what is your general reaction to this procedure?

_____ very negative _____ ambivalent _____ very positive

16. How difficult would this procedure be to put into practice?

_____ extremely _____ neutral _____ extremely
easy difficult

17. How useful would this procedure be?

_____ extremely _____ neutral _____ extremely
useless useful

TEACHING METHOD

Please complete the items listed below. The items should be completed by placing a checkmark on the line under the question that best indicates how you feel about the TEACHING METHOD. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended. REMEMBER, EVALUATE THE TEACHING METHOD AS IF YOU WERE THE PARENT OF A CHILD IN THE FAMILY SITUATION DESCRIBED EARLIER.

1. How acceptable do you find this teaching method to be for the child's problem behavior?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable

2. How willing would you be to carry out this teaching method yourself if you had to change the child's problems?

_____	_____	_____	_____
not at all		moderately	very
willing		willing	willing

3. How suitable is this teaching method for children who might have other behavioral problems than those described for this child?

_____	_____	_____	_____
not at all		moderately	very
suitable		suitable	suitable

4. If children had to be assigned to this program without their consent, how bad would it be to give them this teaching method?

_____	_____	_____	_____
very bad		moderately	not bad
		bad	at all

5. How cruel or unfair do you find this teaching method?

_____	_____	_____	_____
very cruel		moderately	not cruel
		cruel	at all

6. Would it be acceptable to apply this teaching method to institutionalized children, the mentally retarded, or other individuals who are not given an opportunity to choose treatment for themselves?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable
to apply this			to apply
teaching method			this teaching
			method

7. How consistent is this teaching method with common sense or everyday notions about how new parenting procedures should be introduced to a child?

very
different or
inconsistent

moderately
consistent

very
consistent
with everyday
notions

8. To what extent does this teaching method treat the child humanely?

does not
treat
humanely at
all

treats them
moderately
humanely

treats them
very
humanely

9. To what extent do you think there might be risks in undergoing this kind of teaching method?

lots of risks
are likely

some risks are
likely

no risks
are likely

10. How much do you like the procedures used in this teaching method?

do not like
them at all

moderately
like them

like them
very much

11. How effective is this teaching method likely to be?

not at all
effective

moderately
effective

very
effective

12. How likely is this teaching method to make permanent improvements in the child?

unlikely

moderately
likely

very
likely

13. To what extent are undesirable side effects likely to result from this kind of teaching method?

many
undesirable
side effects
likely

some
undesirable
side effects
likely

no
undesirable
side effects
would occur

14. How much discomfort is the child likely to experience during the course of this teaching method?

very much
discomfort

moderate
discomfort

no
discomfort
at all

15. Overall, what is your general reaction to this teaching method?

_____ very negative _____ ambivalent _____ very positive

16. How difficult would this teaching method be to put into practice?

_____ extremely _____ neutral _____ extremely
easy difficult

17. How useful would this teaching method be?

_____ extremely _____ neutral _____ extremely
useless useful

OVERALL PARENT TRAINING PROGRAM

Please complete the items listed below. The items should be completed by placing a checkmark on the line under the question that best indicates how you feel about the OVERALL PARENT TRAINING PROGRAM. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended. REMEMBER, EVALUATE THE OVERALL PARENT TRAINING PROGRAM AS IF YOU WERE THE PARENT OF A CHILD IN THE FAMILY SITUATION DESCRIBED EARLIER.

1. How acceptable do you find this program to be for the child's problem behavior?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable

2. How willing would you be to carry out this program yourself if you had to change the child's problems?

_____	_____	_____	_____
not at all		moderately	very
willing		willing	willing

3. How suitable is this program for children who might have other behavioral problems than those described for this child?

_____	_____	_____	_____
not at all		moderately	very
suitable		suitable	suitable

4. If children had to be assigned to this program without their consent, how bad would it be to give them this program?

_____	_____	_____	_____
very bad		moderately	not bad
		bad	at all

5. How cruel or unfair do you find this program?

_____	_____	_____	_____
very cruel		moderately	not cruel
		cruel	at all

6. Would it be acceptable to apply this program to institutionalized children, the mentally retarded, or other individuals who are not given an opportunity to choose treatment for themselves?

_____	_____	_____	_____
not at all		moderately	very
acceptable		acceptable	acceptable
to apply this			to apply
program			this program

7. How consistent is this program with common sense or everyday notions about what a program should be?

_____	_____	_____
very different or inconsistent	moderately consistent	very consistent with everyday notions

8. To what extent does this program treat the child humanely?

_____	_____	_____
does not treat humanely at all	treats them moderately humanely	treats them very humanely

9. To what extent do you think there might be risks in undergoing this kind of program?

_____	_____	_____
lots of risks are likely	some risks are likely	no risks are likely

10. How much do you like the procedures used in this program?

_____	_____	_____
do not like them at all	moderately like them	like them very much

11. How effective is this program likely to be?

_____	_____	_____
not at all effective	moderately effective	very effective

12. How likely is this program to make permanent improvements in the child?

_____	_____	_____
unlikely	moderately likely	very likely

13. To what extent are undesirable side effects likely to result from this program?

_____	_____	_____
many undesirable side effects likely	some undesirable side effects likely	no undesirable side effects would occur

14. How much discomfort is the child likely to experience during the course of this program?

_____	_____	_____
very much discomfort	moderate discomfort	no discomfort at all

Appendix C

Appendix D

DEMOGRAPHIC DATA FORM

We would like to learn more about the participants in this study. Please help by answering the following questions.

1. What are the ages and sex of your children?

Sex

Birthdate (Include year of birth)

2. What is your current marital status? (Check)

☐ single ☐ divorced ☐ widowed ☐ married/long-term relationship ☐ separated

3. What is your age? _____

4. What is the highest level of education you have completed? (Check)

☐ Grade School ☐ High School ☐ College ☐ University ☐ Graduate School

5. What is your occupation? _____

6. Who is the major wage earner of your household? _____

IF SELF, OMIT QUESTIONS 7 AND 8 AND GO TO QUESTION 9.

7. What is the occupation of the major wage earner in your household?

8. What is the highest level of education completed by the major wage earner?

☐ Grade School ☐ High School ☐ College ☐ University ☐ Graduate School

9. Have you ever sought psychological assistance for your child's behavior or attended parenting courses? (Check)

☐ Yes ☐ No

10. If yes, what was the nature of this assistance?

Appendix E

INTRODUCTION

Thank you for your willingness to participate in this study. The purpose of this study is to have you, as mothers of children in the 3- to 8-year-old range, evaluate a widely used parent training program and the individual skills taught in it.

Parents of children in this age range who seek professional assistance for their child's behavior frequently complain that their child does not obey their requests. This disobedience is a common component of many behavior disorders of young children. The type of child that is excessively disobedient is usually also irritable, negative, destructive, aggressive, stubborn, and frequently resorts to yelling, whining, and crying. He or she may also fight with brothers, sisters, or other children; break rules; tease others; and have temper tantrums. In these families, the parent-child interaction has deteriorated over time to the point where it has become very negative and is usually characterized by frequent scolding, nagging, threatening, yelling, and spanking. When families become this disrupted, it is likely that family members view each other and themselves very negatively. As a result of this whole process, family members tend to avoid each other and share very few activities together.

The parenting program you will be evaluating has been developed specifically as a treatment for families who find themselves in this situation. WHEN EVALUATING THIS PROGRAM, TRY TO IMAGINE YOURSELF AS THE PARENT OF AN EXCESSIVELY DISOBEDIENT CHILD IN THE FAMILY SITUATION JUST DESCRIBED.

This parent training program is based on the premise that much of a

child's behavior is learned and the best approach in dealing with the child's undesirable* behavior is by teaching the child more acceptable behaviors. Young children are most influenced by their parents, so the goal of parent training is to teach the parents more effective ways of interacting with their children. This particular program is most effective for parents of young children (ages 3 to 8 years).

There are two ways to reduce a child's undesirable behavior. The first is by focusing on the inappropriate (or "bad") behavior directly. This usually involves some form of punishment. The disadvantage of this approach is that appropriate or "good" behavior does not necessarily increase since punishment only tells the child what not to do. Additionally, the parent has to punish the child frequently, which can be distressing for both parent and child.

The second and more advantageous method is to focus first on increasing the child's desirable or "good" behavior. By doing so, undesirable behavior automatically decreases. Since the child spends more time being "good", there is less time available to be "bad". This method teaches the child exactly what behavior is appropriate. The parent can then punish less frequently and punishment can be more effective when it is used. Also, focusing on the "good" behavior improves the parent-child relationship and makes for a more pleasant family life.

*By undesirable or inappropriate behavior we mean behavior that you as a parent would like to see decreased or eliminated (for example, hitting, whining). Similarly, desirable and appropriate behavior refers to behavior that a parent sees as acceptable behavior or behavior you would like to see increased (for example, toothbrushing, sharing toys).

Parents in this two-part program are taught a series of parenting skills that help to change their way of interacting with their child. The program is taught in a clinic with individual families. Families usually come to the clinic once a week for 8 to 12 weeks. Parents progress to each new parenting skill at their own speed. New skills are not taught until parents are proficient and comfortable with the previous skill. Each new skill builds upon the previous skills.

For each new skill, the therapist explains and demonstrates its use to the parent. The parent then practices the new skill in the clinic with the therapist role-playing (acting the part of) the child. This way the parent can become very skillful and comfortable with the technique before using it with their own child.

P [The parent does not explain or demonstrate the new skill to the child before it is actually used with the child. This allows the child to learn naturally by experience and by trial and error how the new skill will be used.]

PR [The parent then verbally explains the new skill to the child before it is actually used with the child. By having the skill described first, the child understands the new procedure and learns to change his or her behavior more quickly than learning by experience and trial and error.]

PRM [The parent then verbally explains and demonstrates the new skill to the child before it is actually used with the child. By having the skill described first, the child understands the new procedure and learns to change his or her behavior more quickly than learning by experience and trial and error. Showing the child how the new skill will be used reinforces what has already been explained.]

The parent then practices the new skill with the child in the clinic, receiving feedback and encouragement from the therapist. Once the parent is

comfortable with the new parenting skill and is using it successfully in the clinic with the child, then the parent uses the new skill in the home. Parents are assigned specific homework exercises at each session to enable them to use the new skills successfully at home.

INSTRUCTIONS

In this study, you will read about the two parts of the parenting program and the skills taught in each part. After each skill is described, you will evaluate it by rating it on the questionnaire that follows. In the final segment, you will evaluate the teaching method and the entire parent training program as a whole. Please read the descriptions carefully and proceed at your own pace.

REMEMBER, EVALUATE THIS PROGRAM AS IF YOU WERE THE PARENT OF A CHILD IN THE FAMILY SITUATION DESCRIBED ON PAGE 1.

OVERVIEW FOR PART I

The goal of Part I of the program is to teach the parent skills that will help to increase the child's appropriate or "good" behavior and help the child learn which behaviors need to be decreased. There are two assumptions underlying Part I:

1. When a behavior gets positive consequences immediately after it occurs, the behavior is likely to occur again. For example, if you tell a joke at a party and everyone laughs, you are more likely to tell another joke.
2. For children, attention from others, especially parents, is the most powerful consequence. Children will work to get their parent's attention. If the child is not getting positive attention (for example, praise) the child will also work for negative attention (for example, scolding, criticism), which to the child, is considered better than no attention at all.

Parental attention, therefore, is very powerful to the child and can be used to change the child's behavior.

In Part I, the parent is taught to use positive attention for appropriate behavior and to withhold attention for undesirable behavior. The skills taught in Part I help the parent learn to interact with their child in a more positive manner and improve that relationship.

Three parenting skills are taught in Part I:

1. attends
2. rewards
3. ignoring

Effective use of these three skills together will eliminate a large portion of the child's undesirable behavior, and improve the relationship between parent and child.

ATTENDS

The first skill taught in Part I is attends. Basically, attends are a running verbal commentary of the child's activity and supply the child with a constant source of attention. Attends can simply be descriptions of the child's behavior (for example, "You're piling the blocks on top of each other.") or they can be used to emphasize a behavior the parent would like to see more of (for example, "You're playing all by yourself!" or "You're sharing your toys with your sister.").

To attend well, the parent is taught to:

1. Be attentive to the child's activity. Attends are not effective when the parent is trying to do something else (for example, reading the newspaper). The child's activity must be followed closely.
2. Avoid asking the child questions, teaching, or giving the child directions on how to play.
3. Attend only to desirable behavior. Do not give attention to behavior that is inappropriate or that the parent would like to decrease.

The parent may at first feel awkward in using this new style of interacting with the child. However, this uncomfortableness quickly passes as the parent uses this skill in many situations. Similarly, once children become accustomed to being attended to, they enjoy it immensely.

The rationale for attends is explained to the parent by the therapist. The therapist then demonstrates to the parent how attends are used. The parent then practices using attends with the therapist playing the role of the child.

P [Once the parent is skilled at using attends with the therapist, the parent begins to use attends with the child without explaining or demonstrating it first.

The parent practices the use of attends with the child in the clinic and at home in special play times set aside daily for this purpose.]

PR [Once the parent is skilled at using attends with the therapist, the parent then explains the use of attends to the child before they are actually used with the child. Depending on the child's age, the parent might introduce attends by saying: " (Name), from now on when we are playing together, I'm going to be watching very closely and when you play nicely it will make me very happy. I will be talking about the good things you are doing. You'll like it!"

After explaining attends to their child, the parent practices the use of attends with the child in the clinic and at home in special play times set aside daily for this purpose.]

PRM [Once the parent is skilled at using attends with the therapist, the parent then explains and demonstrates the use of attends to the child before they are actually used with the child. Depending on the child's age, the parent might introduce attends by saying: " (Name), from now on when we are playing together, I'm going to be watching very closely and when you play nicely it will make me very happy. I will be talking about the good things you are doing. You'll like it! To show you what its going to be like, let's practice. Pretend you're playing with these blocks. (Parent guides child.) I might say things like, 'You're gathering all of the blocks together. Now you're stacking them on top of each other... first the blue one, then the green one...' Do you understand?"

After explaining and demonstrating attends to the child, the parent practices the use of attends with the child in the clinic and at home in special play times set aside daily for this purpose.]

PLEASE EVALUATE ATTENDS ON THE FOLLOWING QUESTIONNAIRE.

REWARDS

Rewards, the second skill taught in Part I, help to increase a child's appropriate or "good" behavior and is useful in teaching new behaviors. There are three types of rewards:

1. Physical affection. For example, kiss, hug, pat on the back.
2. General praise. For example, "Thanks!" "Good girl!" "Great!"

Though these praise statements are positive, they do not specifically tell the child what behavior they are being rewarded for.

3. Specific praise. For example, "Thanks for bringing my shoes!" "I really like it when you share your toys with your brother." These types of rewards are specific statements which tell the child which behavior is being rewarded and are most useful in teaching the child appropriate behaviors.

To maximize the effectiveness of rewards, it is important to give specific praise immediately following the behavior. When a child is first learning a new behavior, give rewards consistently. Once the child has learned the new behavior, reduce the frequency of rewards. Rewards are most effective when used with attends. Rewards can lose their power if used too frequently. Attends can be used flexibly in many situations while rewards are best used for especially good behavior.

Once rewards are explained to the parent, the therapist demonstrates their use. The parent then practices using attends and rewards with the therapist acting as the child.

P [When the parent is skilled at using attends and rewards together, the parent begins to use the new skill with the child, but does not explain or demonstrate it first.

The parent practices using rewards with the child in the clinic and then at home in daily play times.]

PR [When the parent is skilled at using attends and rewards together, the parent verbally explains to the child how rewards will be used. Depending on the age of the child, the parent might introduce rewards by saying to the child: "(Name), from now on when I see you doing something I really like, I'll be happy and I'll tell you right away how much I like what you did."

Once rewards have been explained to the child, the parent practices using rewards with the child in the clinic and then at home in daily play times.]

PRM [When the parent is skilled at using attends and rewards together, the parent verbally explains and demonstrates to the child how rewards will be used. Depending on the age of the child, the parent might introduce rewards by saying to the child: "(Name), from now on when I see you doing something I really like, I'll be happy and I'll tell you right away how much I like what you did. Let's pretend that you are playing really quietly over there with that truck. (Parent guides child.) I really like it when you play quietly so I'm going to come over to you and tell you. (Parent goes over to the child.) I'll say something like, 'I really like it when you play so quietly, (name)!'"

Once rewards have been explained and demonstrated to the child, the parent practices using rewards with the child in the clinic and then at home in daily play times.]

PLEASE EVALUATE REWARDS ON THE FOLLOWING QUESTIONNAIRE. KEEP IN MIND THAT REWARDS WOULD BE USED IN CONJUNCTION WITH ATTENDS IN ORDER TO INCREASE POSITIVE OR "GOOD" BEHAVIOR.

IGNORING

An important and effective way to decrease a child's minor inappropriate behavior is to ignore it. Ignoring the behavior means that absolutely no attention at all is given to it. Behaviors that do not receive attention of any type (either positive or negative) will tend to decrease. One aspect that makes ignoring difficult for parents is that when a parent ignores an undesirable behavior, the child will often increase the behavior in an attempt to get the attention he or she once received. However, if the parent can consistently ignore the behavior, it will soon decrease.

In order to make ignoring as effective as possible, the parent is taught to:

1. Begin ignoring as soon as the undesirable behavior starts.
2. Avoid making eye contact or giving nonverbal cues such as smiling or frowning to the child. To prevent the child from seeing the parent's facial expression, the parent is instructed to turn at least 90 degrees away from the child.
3. Avoid talking to the child while the child is behaving inappropriately.
4. Avoid physical contact with the child while the child is behaving inappropriately.
5. Stop ignoring as soon as the child is behaving appropriately.

Ignoring can be extremely effective and useful but should NOT be used in situations where the child's behavior is harmful or potentially could cause harm to the child, others, or property (for example, colouring the walls). A more appropriate technique for these situations is taught in Part II.

After the ignoring skill is explained to the parent, the therapist demonstrates how the procedure is used. The parent then practices the procedure with the therapist role-playing the child.

P [When the parent is proficient at using this skill with the therapist, the parent uses the new procedure without explaining or demonstrating it first to the child.

The parent practices using ignoring, when appropriate, in the clinic and then at home.]

PR [When the parent is proficient at using this skill with the therapist, the parent then explains the new procedure to the child before it is used with the child. To introduce ignoring to the child, the parent might explain: "(Name), from now on when you do things I like, I'll be very happy. If you do things I don't like to see, I will be unhappy and I'll ignore you. That means I'll turn away and not look at you or talk to you. When you start to do things I like, I'll start talking to you again. Do you understand?"

After ignoring has been explained to the child, the parent practices using ignoring, when appropriate, in the clinic and then at home.]

PRM [When the parent is proficient at using this skill with the therapist, the parent then explains and demonstrates the new procedure to the child before it is used with the child. To introduce ignoring to the child, the parent might explain: "(Name), from now on when you do things I like, I'll be very happy. If you do things I don't like to see, I will be unhappy and I'll ignore you. That means I'll turn away and not look at you or talk to you. When you start to do things I like, I'll start talking to you again. Do you understand? To make sure you understand what ignoring is, let's pretend you want to get my attention. Instead of asking nicely, you use your baby voice (that is, whining). So I'll pretend you're whining. I don't like you to

do that, so I'm going to ignore you like this. (The parent then demonstrates ignoring for about 10 seconds.) The only way to get me to stop ignoring you is to talk in your normal voice. (When the child talks in their regular voice, the parent stops ignoring). Now you know what ignoring is."

After ignoring has been explained and demonstrated to the child, the parent practices using ignoring, when appropriate, in the clinic and then at home.]

Parents practice the use of attends, rewards, and ignoring at home in special play times set aside for this purpose. Parents are also asked to think of three behaviors they would like to see their child do more often (for example, pick up their toys, get dressed by themselves in the morning). Parents are taught how to use the Part I skills in meeting these goals. As the parents become more proficient with the skills, they are encouraged to apply them to everyday situations.

PLEASE EVALUATE IGNORING ON THE FOLLOWING QUESTIONNAIRE. KEEP IN MIND THAT IGNORING (TO DECREASE UNDESIRABLE OR "BAD" BEHAVIOR) WOULD ONLY BE USED IN CONJUNCTION WITH ATTENDS AND REWARDS (TO INCREASE POSITIVE OR "GOOD" BEHAVIOR).

OVERVIEW FOR PART II

In Part II, the parent is taught how to deal directly with any disobedience that remains. The skills of Part II are effective only when used in combination with the skills of Part I (attends, rewards, ignoring) and therefore, Part II skills are never taught first or alone. They are taught only after the parent is effectively using attends, rewards, and ignoring.

The skills of Part II focus on things parents can do to increase the likelihood of their child obeying and decrease the likelihood that their child will disobey.

The skills of Part II are:

1. Giving clear instructions.
2. Using a time-out sequence for disobedience to instructions.

How a parent gives instructions often influences whether or not the child will obey. Parents often fall into the habit of giving instructions that are difficult to obey. For example:

"Watch out!" "Be good!"--too vague. These instructions do not tell the child specifically what is expected.

"Pick up your blocks, put them on the shelf, then make your bed and put your clothes away."--too many to remember!

"Would you like your bath now?"--offers the child a choice where no choice was intended.

"Let's put the dishes away."--often the parent has no intention of helping.

Parents are instructed to avoid these kinds of instructions and instead, to give clear, direct instructions so that if their child does not obey, it is because the child chooses not to obey, rather than not being able to understand the instructions. The parent is taught to give positive attention (attends, rewards) as soon as the child begins to follow the instruction. Since obeying the parent's instruction is desirable, the parent should be sure to give the child positive attention. A procedure for handling disobedience is taught in the next section.

The parent is taught to give good instructions. These are characterized by:

1. Deciding ahead of time whether the instruction is necessary. Often the parent can use the skills of Part I of the program to get the same result.
2. Giving instructions only when the parent is prepared to follow through should their child decide not to obey.
3. Getting the child's attention. The parent calls the child's name and waits until he or she is looking at the parent.

4. Voice should be firm and slightly louder than usual. This helps the child understand that these instructions are important to listen to.
5. The instruction should be specific and direct and should be phrased in a way the child can understand.
6. Instructions should be phrased as "do" rather than "stop" since this tells the child what is expected. For example, "Tommy, share the toys with your sister", rather than "Stop hitting your sister."
7. Instructions should be given one at a time.
8. After giving the instructions, wait 5 seconds to give the child the opportunity to begin to obey. (Research has shown that after 5 seconds, the likelihood that the child will obey the instruction sharply decreases.) To avoid distracting the child from starting the task, the parent does not speak to the child during these 5 seconds.
9. As soon as the child starts to follow the instruction, the parent uses attends and rewards to ensure that the child completes the instruction and to provide positive attention for obeying. ("Now you're gathering the blocks to put in the toy box...you're checking to make sure you haven't missed any...Thank you for putting the toys away. I really like it when you do what I ask.")

After the skill has been explained and demonstrated to the parent, the parent practices giving clear instructions to the therapist in the clinic.

P [The parent then begins to use the new skill with the child, but does not explain or demonstrate it first.

The parent practices giving clear instructions in the clinic and then at home.]

PR [The parent then explains to the child how clear instructions will be used. To introduce clear instructions to the child, the parent might explain:

" (Name), when I want you to do something for me, I'm going to call your name first, and then tell you what I'd like you to do. I'm only going to say it once. It's very important to me and will make me happy if you do what I ask quickly. After I ask you to do this for me I'll wait 5 seconds. When you start to do what I asked, I'll talk about what you're doing and tell you right away how much I like it."

Once clear instructions are explained to the child, the parent practices giving clear instructions in the clinic and then at home.]

PRM [The parent then explains and demonstrates to the child how clear instructions will be used. To introduce clear instructions to the child, the parent might explain: " (Name), when I want you to do something for me, I'm going to call your name first, and then tell you what I'd like you to do. I'm only going to say it once. It's very important to me and will make me happy if you do what I ask quickly. After I ask you to do this for me I'll wait 5 seconds. When you start to do what I asked, I'll talk about what you're doing and tell you right away how much I like it. Let's pretend I want you to put your coat on. First I'll call your name and then I'll tell you what I'd like you to do. Ready? ' (Name), (parent waits until the child looks at the parent) please put your coat on.' (Child gets coat and begins to put it on.) 'You've found your coat... You're zippering it up...Thank you for putting your coat on. I really like it when you do what I ask.' That's how I'm going to tell you to do things for me."

Once clear instructions are explained and demonstrated to the child, the parent practices giving clear instructions in the clinic and then at home.]

Clear instructions can be summarized by this flow chart:

PLEASE EVALUATE CLEAR INSTRUCTIONS ON THE FOLLOWING QUESTIONNAIRE.

REMEMBER THAT THIS PROCEDURE INCLUDES PRAISE (ATTENDS AND REWARDS) FOR FOLLOWING THE PARENT'S INSTRUCTION AS WELL. KEEP IN MIND THAT CLEAR INSTRUCTIONS WOULD ONLY BE USED IN CONJUNCTION WITH ATTENDS, REWARDS, AND IGNORING IN ORDER TO INCREASE POSITIVE OR "GOOD" BEHAVIOR AND DECREASE UNDESIRABLE OR "BAD" BEHAVIOR.

TIME-OUT SEQUENCE

The last skill taught in the program is a technique to handle the child's failure to obey a parent's instruction. As you have just read in the preceding section, the parent is taught to wait 5 seconds after giving an instruction. If the child begins to obey, the parent attends to and rewards the child.

If the child does not begin to obey within 5 seconds, then the parent is taught how to use a time-out procedure. Time out is when the child is removed from the situation by having the child sit on a chair in the corner for 3 minutes. Time out is simply a more extreme form of ignoring where the child is removed from all sources of attention (other people, parents) and entertainment (toys, television). The advantage of using time out is that it can be used in place of other forms of discipline such as yelling, criticizing, or hitting, and the parent can avoid reacting in anger.

The time-out sequence consists of a series of alternative steps which are determined by the child's responses to the parent's instructions. The sequence goes as follows. The parent gives a clear, direct instruction. If the child has not started to obey within 5 seconds, the parent gives a warning that specifies the instruction and the consequences of not obeying (for example, "If you do not pick up the toys, then you will have to sit in the chair.") If the child obeys the warning, then the parent immediately praises the child (for example, "Thank you for ..."). However, if the child has not begun to obey within 5 seconds, the parent can be sure that the child has no intention of obeying. The parent gave a clear, direct instruction; waited; and gave the child a warning in which the instruction was restated and the

child was told what would happen if the he or she did not obey. The child is then taken firmly by the hand to a chair facing the corner of a room. The child is told, "Since you didn't (instruction), you will have to sit in the chair until I say you can get up." The parent does not argue or give any further explanations. Any temper tantrums, crying, promises, or protests on the way to time out or during time out should be ignored.

The child should stay in time out for 3 minutes. Research has indicated that 3 minutes is an ideal period for time out. Time out for less than 3 minutes is less effective while time out for greater than 3 minutes does not lead to greater obedience. When 3 minutes are up, the parent removes the child from the chair and returns to the area where the original instruction was given. The parent then reissues the same instruction, beginning the sequence again. This is an important step! Children learn that they must still follow through on the original instruction. It is extremely rare that the parent must go through the cycle more than once for the original instruction. Occasionally, when first learning the new procedure, the child may not stay in the chair. The parent then uses a back-up consequence, such as two swats on the child's bottom or some other punishment (for example, removal of privileges).

After the therapist has explained the sequence to the parent, the therapist demonstrates the procedure with the parent, going through the various alternative steps. The parent then practices the procedure with the therapist role-playing the child until the parent is very proficient at using the skill.

P [When the parent is ready to use the new skill with the child, the parent does not verbally explain or demonstrate the new procedure to the child before using it.

Once the parent is skilled at using time out in the clinic, the parent can begin using time out at home, when appropriate.]

PR [When the parent is ready to use the new skill with the child, the parent then verbally explains the new procedure to the child before using it. The parent might explain: "(Name), when I ask you to do things for me, it is very important that you do what I ask you to do very quickly. If you do things for me quickly, then I'll be happy. If you don't do things for me, I'll ask you once more. If you still don't do what I ask quickly, then I'll be very unhappy and I'll take you to the corner. You'll have to sit on that chair in the corner for 3 minutes. Sitting in the corner will help you to learn to do things more quickly. When 3 minutes are up, you can get off the chair, but you'll have to do what I asked you to do before. Otherwise, you'll have to go back to the chair. Do you understand?"

Once the parent has explained the procedure to their child and is skilled at using time out in the clinic, the parent can begin using time out at home, when appropriate.]

PRM [When the parent is ready to use the new skill with the child, the parent then verbally explains and demonstrates the new procedure to the child before using it. The parent might explain: "(Name), when I ask you to do things for me, it is very important that you do what I ask you to do very quickly. If you do things for me quickly, then I'll be happy. If you don't do things for me, I'll ask you once more. If you still don't do what I ask quickly, then I'll be very unhappy and I'll take you to the corner. You'll have to sit on that chair in the corner for 3 minutes. Sitting in the corner will help you to learn to do things more quickly. When 3 minutes are up, you can get off the chair, but you'll have to do what I asked you to do before. Otherwise, you'll have to go back to the chair. Do you understand? To make

sure we know what to do, let's practice. Pretend you're playing with your doll. (Parent guides child.) Now I'll ask you to do something for me. '(Name), please put your doll on the shelf.' (Whisper) Now pretend not to do it. (Wait 5 seconds.) Then I'll say, "If you don't put your doll on the shelf, you will have to sit on the chair.' (Whisper) Pretend not to do it. (Wait 5 seconds.) Then I'll say, 'Since you didn't do what I asked, you'll have to sit in the corner.' Then you go over and sit on the chair. (Parent guides.) That's it! Then we'll wait for 3 minutes. Then I'll say, 'You can get off the chair now.' Then I'll ask you to do what I asked you to do before. '(Name), please put your doll on the shelf.' (Whisper) Now pretend to do it. (Child puts doll on the shelf.) Thank you for putting your doll on the shelf!"

Once the parent has explained and demonstrated the procedure to the child and is skilled at using time out in the clinic, the parent can begin using time out at home, when appropriate.]

Once the parent is proficient in the use of time out at home, the parent is also taught modifications of time out for other situations, such as misbehavior in public places like the grocery store or for establishing long standing "house rules".

Part II of the program can be summarized by this flow chart:

PLEASE EVALUATE THE TIME-OUT SEQUENCE ON THE FOLLOWING QUESTIONNAIRE.

KEEP IN MIND THAT IT WOULD BE USED ONLY IN CONJUNCTION WITH ATTENDS, REWARDS, IGNORING, AND CLEAR INSTRUCTIONS IN ORDER TO INCREASE POSITIVE OR "GOOD" BEHAVIOR AND DECREASE UNDESIRABLE OR "BAD" BEHAVIOR.

As you have seen, this parent training program uses a standard method of teaching the parent the new skills and a standard method of introducing the new skills to the child. In this program, the therapist first explains to the parent the rationale for the new skill, then demonstrates how it is used. The parent then role-plays the new skill with the therapist.

We are interested in your evaluation of the manner in which the new skills are introduced TO THE CHILD BY THE PARENT.

P [Remember, without explaining or demonstrating the new technique to the child, the parent begins to use the technique with the child in the clinic and at home. This is done so that the child can learn naturally how the new skill will be used by experience and by trial and error.]

PR [Remember, when the parent is proficient at the new technique, the parent explains the technique to the child before using it with the child in the clinic and at home. This is done so that the child understands the new procedure and learns to change his or her behavior more quickly and with less "hassle" than learning only by experience and trial and error.]

PRM [Remember, when the parent is proficient at the new technique, the parent explains the technique to the child and then demonstrates it before using it with the child in the clinic and at home. This is done so that the child understands the new procedure and learns to change his or her behavior more quickly and with less "hassle" than learning only by experience and trial and error. By having the parent also demonstrate the technique to the child, the child can be shown how the new skill will be used. This demonstration reinforces what has already been explained.]

PLEASE EVALUATE THE METHOD OF INTRODUCING THE NEW SKILL TO THE CHILD ON THE FOLLOWING QUESTIONNAIRE.

OVERALL PROGRAM

Before evaluating the parent training program as a whole, think about the entire program, its rationale, its individual skills, and the way in which they are used together. Remember, this program is designed for families who have an excessively disobedient child (ages 3 to 8 years) and whose interactions with their child have become very negative.

Consider the program skills:

PART I: improving the interaction between parent and child; using positive attention for appropriate behavior and withholding attention for inappropriate behavior; takes care of a large portion of the child's undesirable behavior.

The skills that are taught are:

Attends: providing a running commentary on the child's activity and supplying a positive source of attention.

Rewards: positive attention for good behavior (for example, praise).

Ignoring: withdrawal of attention for undesirable behavior.

PART II: ways to increase the likelihood the child will follow parental directions.

Clear Instructions: giving clear, specific instructions; one at a time; positive attention for obedience.

Time-out sequence: giving a time-out procedure for failure to obey instructions.

Also, consider the manner and sequence in which the various skills are taught to the parent (explanation, demonstration, and roleplay) and to the child P [(experience, trial and error).], PR [(explanation).], PRM [(explanation and demonstration).].

ON THE FINAL QUESTIONNAIRE, EVALUATE THE PARENT TRAINING PROGRAM AS A WHOLE PROGRAM.

Appendix F

Analysis of Variance Results of TEI Scores for Mediatlional Groups and Techniques

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediatlional group	2	2444.669	4.15	.019
Error	87	589.195		
Technique	4	6003.681	50.70	.001
Technique x mediatlional group	8	180.691	1.53	.147
Error	348	118.426		

Analysis of Variance Results of TEI Scores for Teaching Method

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediatlional group	2	734.533	4.30	.017
Within groups	87	170.682		

Analysis of Variance Results of TEI Scores for Overall Program

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediatlional group	2	1204.878	7.12	.001
Within groups	87	169.127		

Appendix G

Newman-Keuls Comparisons of Techniques

Dependent Measure	Technique				
TEI	<u>Rewards</u>	<u>Commands</u>	Attends	Time out	Ignoring
Usefulness	Commands	<u>Rewards</u>	<u>Attends</u>	<u>Time out</u>	Ignoring
Difficulty	Rewards	<u>Commands</u>	<u>Attends</u>	Time out	Ignoring

Note. Any two techniques underlined by the same line are not significantly different, whereas any two techniques not underlined by the same line are significantly different. All differences are at the $p < .05$ level.

N=90.

Appendix H

Newman-Keuls Comparisons of Mediational Group on Ratings of Acceptability

Mediational teaching method	PR	<u>P</u>	<u>PRM</u>
Overall program	<u>PR</u>	<u>P</u>	PRM

Note. P=parent training only; PR=parent training plus verbal rationale; PRM=parent training plus verbal rationale and modeling. Any two groups underlined by the same line are not significantly different, whereas any two groups not underlined by the same line are significantly different. All differences are at the $p < .05$ level .
 $n=30$ per group.

Appendix I

Analysis of Variance Results of Usefulness Ratings for Mediational Groups and Techniques

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	4.460	1.35	.265
Error	87	3.305		
Technique	4	12.759	12.59	.001
Technique x mediational group	8	.599	.59	.785
Error	348	1.013		

Analysis of Variance Results of Usefulness Ratings for Teaching Method

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	.844	.75	.477
Within groups	87	1.130		

Analysis of Variance Results of Usefulness Ratings for Overall Program

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	1.600	1.63	.202
Within Groups	87	.981		

Appendix J

Analysis of Variance Results of Difficulty Ratings for Mediational Group and Techniques

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	27.736	3.78	.027
Error	87	7.335		
Technique	4	35.759	17.70	.001
Technique x mediational group	8	1.727	.85	.555
Error	348	2.021		

Analysis of Variance Results of Difficulty Ratings for Teaching Method

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	5.733	2.22	.115
Within groups	87	2.585		

Analysis of Variance Results of Difficulty Ratings for Overall Program

Source	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Mediational group	2	4.678	1.93	.151
Within groups	87	2.425		