DOCUMENT RESUME

ED 432 877 EC 307 366

AUTHOR Kratochwill, Thomas R.; Elliott, Stephen N.; Loitz, Pamela Ann; Sladeczek, Ingred; Carlson, John

TITLE An Experimental Analysis of Teacher/Parent Mediated Interventions for Preschoolers with Behavioral Problems. Final Report.

INSTITUTION Wisconsin Center for Education Research, Madison.
SPONS AGENCY Office of Special Education and Rehabilitative Services (ED), Washington, DC.
PUB DATE 1999-08-00
NOTE 287p.
CONTRACT H023C20172
PUB TYPE Reports - Research (143)
EDRS PRICE MF01/PC12 Plus Postage.
DESCRIPTORS *Behavior Disorders; *Behavior Modification; Inservice Teacher Education; *Instructional Effectiveness; Parent Education; *Preschool Children; Preschool Education; *Training Methods; *Videotape Recordings
IDENTIFIERS Project Head Start

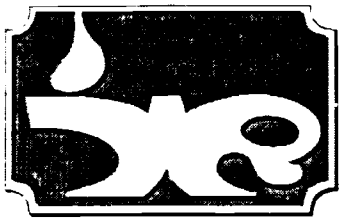
ABSTRACT

This report discusses the outcomes of a study that tested the effectiveness and compared two different approaches of conjoint behavioral consultation using a manual versus a videotape series as the main components of training parents and teachers to treat children's behavioral difficulties. Children (n=68) exhibiting externalizing or internalizing behavioral problems who attended Head Start Programs were targeted for this intervention. During the first 2 years of the project, a manual-based program was conducted. The last 3 years of the project involved delivery of the parent/teacher training program through a series of videotapes and accompanying manuals. Children were randomly assigned to either an experimental or no-treatment control group. Results indicated that both of the treatment groups demonstrated improved behaviors within more cases when compared to the control group, and that the manual treatment group reported the greatest number of behavioral improvements. Direct behavioral observations did not indicate clinically relevant improvements in behavior; however, parent and teacher goal attainment reports characterized students as meeting their behavioral goals overall. Both parents and teachers also reported high rates of treatment acceptability and satisfaction with both the manual and videotape treatment programs. Appendices include the assessment instruments. (Contains approximately 90 references.) (CR)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 432 877

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.



August 1999

An Experimental Analysis of Teacher/Parent Mediated Interventions for Preschoolers with Behavioral Problems

Thomas R. Kratochwill and Stephen N. Elliott

A final report to the Office of Special Education and Rehabilitative Services on Grant No. H023C20172

Wisconsin Center for Education Research
School of Education University of Wisconsin–Madison

EC 307366

An Experimental Analysis of Teacher/Parent Mediated Interventions for Preschoolers with Behavioral Problems

Thomas R. Kratochwill

Stephen N. Elliott

Pamela Ann Loitz

Ingred Sladeczek

John Carlson

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

APPENDICES

LIST OF TABLES

ABSTRACT

This research involved testing the effectiveness and comparing two different approaches of conjoint behavioral consultation using a manual versus a videotape series as the main components of training parents and teachers to treat children's behavioral difficulties. Children exhibiting externalizing or internalizing behavioral problems who attended Head Start Programs were targeted for this intervention. During the first two years of the project, a manual-based program was conducted. The last three years of the project involved delivery of the parent/teacher training program through a series of videotapes and accompanying manuals. Children were randomly assigned to either an experimental or no-treatment control group. The effectiveness of the intervention within the experimental group was assessed primarily through a pretest-posttest, experimental-control group repeated measures design. The results indicated that both the treatment groups demonstrated improved behaviors within more cases when compared to the control group; the manual treatment group reporting the greatest number of behavioral improvements. Direct behavioral observations did not indicate clinically relevant improvements in behavior, however, parent and teacher goal attainment reports characterized students as meeting their behavior goals, overall. Both parents and teachers also reported high rates of treatment acceptability and satisfaction with both the manual and videotape treatment programs. Implications for future research are discussed.

Chapter I

Introduction

Early identification and treatment of children with social-emotional delays or difficulties has been increasingly deemed as necessary and important. The Individuals with Disabilities Education Act (IDEA, 1997) has stressed the need for preschool and birth-to-three programming and has mandated both in some states. Emphasis on early identification and treatment are warranted, since early onset social-emotional behavioral difficulties are predictive of school difficulty and later behavioral problems (e.g., Rubin & Stewart, 1996; Webster-Stratton, 1996).

Family characteristics and parenting styles also can increase the risk of a child experiencing internalizing or externalizing behavioral difficulties. Rubin and Stewart (1996) suggest from a review of a small literature base that socially withdrawn children are associated with authoritarian parenting styles and parental overprotection. Children who exhibit more externalizing difficulties, such as a conduct disorder, also are associated with authoritarian and inconsistent parenting styles (Webster-Stratton; 1996). Parenting skills and styles are only one of the many factors that increase the risk of social-emotional problems in young children and are amenable to intervention. One way of training adults who teach and parent young children, is through a process referred to as behavioral consultation.

Behavioral consultation has been characterized as an indirect problem-solving approach in which a consultant works with a consultee (e.g., teacher or parent) to improve a particular client's (e.g., student's) behavior (Bergan & Kratochwill, 1990). Behavioral consultation, as the name suggests, has its theoretical roots in behavioral

psychology. An ecological approach is taken, in which the environmental contingencies that maintain behavior (e.g., reinforcement) are analyzed. These environmental variables are often modified to produce change within the targeted behavior of the client. Thus, individuals interacting within the environment, such as parents and teachers, modify their own behavior to produce changes within the client's behavior (Henning-Stout, 1993). To date, most of the behavioral consultation studies have been conducted within schools and focus primarily on consulting with teachers (Kratochwill, 1998; Kratochwill, Sheridan, & Van Someran, 1988). Behavioral consultation with parents has been researched infrequently, however, the parent training literature has some empirical evidence to support parents as change agents for their children's behaviors (Kramer, 1990; O'Dell, 1974).

Traditional formats for training teachers and parents tend to be costly and there seems to be limited resources available for families in need of such services. Parent/Teacher training also can be a time consuming procedure. Many therapists have time constraints that do not allow them enough one-to-one contacts to successfully implement a comprehensive program (Ritchie, 1983; Strother & Jacobs, 1986). Although a behavioral consultation approach can be the guiding organizational format for providing services, an important component of consultation is actually training parents and teachers to use the behavioral techniques correctly. This process may be enhanced by providing parents and teachers with educational materials that can be self-administered, such as treatment manuals and videotapes. Although self-administered materials are abundant and seem like a logical means to train individuals, their overall

effectiveness in changing client behavior has been researched infrequently (Kramer, 1990; Rosen, 1993).

To date, research in the area of adult training has focused mostly on parents (Elliott & Busse, 1993). Within this literature base, various techniques to train parents have been tried. One study in particular combined behavioral consultation with competency-based parent training procedures (Rotto & Kratochwill, 1994). This study focused on developing parent skill acquisition and reducing noncompliant child behavior within the home setting. Parents were trained to use three different parenting techniques including differential attention, instruction giving, and time-out procedures. Parents were trained using a variety of techniques including modeling, role-playing, self-monitoring, and criterion-referenced mastery learning. Results indicated that the treatment was effective in both training parents to use the behavioral techniques (parents reached mastery criterion of skill acquisition) and in reducing noncompliant behaviors in their children.

Research also has been conducted within the area of parent training using self-administered materials and the results have been promising overall. For example, parent training manuals have been the main component to teach behavioral strategies to parents to improve their children's specific behaviors, such as homework completion rates (Anesko & O'Leary, 1982) and videotape modeling has been successful in teaching parents specific behaviors to use in child management, such as time-out procedures (e.g., Nay, 1975). Similarly, the effectiveness of parent training manuals on specific behaviors with little or no contact from the therapist has been researched. For example, parents have been trained via written materials to reduce their children's fear of the dark

(Giebenhain & O'Dell, 1984); decrease their children's inappropriate mealtime behaviors (Bauman, Reiss, Rogers, & Bailey, 1983; McMahon & Forehand, 1978); lessen their children's problematic behaviors during shopping trips (Clark, Greene, Macrae, McNees, Davis, & Risley, 1977); reduce their children's fighting behaviors (Sloane, Endo, Hawkes, & Jenson, 1990); and improve their children's homework completion rates (Loitz & Kratochwill, 1994). In concurrence with the success of the above mentioned studies, Bernal and North (1978) concluded that parent training manuals geared toward discrete child behavior problems are most likely to succeed in changing the child's behavior compared to more complex and generalized problems. As a child's behavior becomes more diffuse, the need for professional guidance may need to be increased. Kramer (1990) stated a similar conclusion "...research has been completed demonstrating that with well-defined, discrete problems, written instructions may assist some parents in improving their skill level" (pp. 687-688).

More encompassing programs for training parents a variety of skills have also produced promising results in the research literature. A videotape series developed to train parents several skills to improve child/parent interactions and child behavior has been developed and recently researched by Carolyn Webster-Stratton and her associates. Specifically, several studies have been conducted to assess the effectiveness of a videotape parent training program for improving younger children's conduct problems. Overall, the evidence supports the videotape program as effective in helping to improve children's behaviors compared to a control group (e.g., Webster-Stratton, Kolpacoff & Hollinsworth, 1988; Webster-Stratton, 1990; Webster-Stratton, 1992).

To illustrate, Webster-Stratton, et. al., (1988) used a self-administered videotape parent training program to improve parent-child interactions. They compared the self-administered training format to two other training programs; a group discussion plus videotape format and a group discussion treatment program, in the effectiveness of improving child behavior problems. Each group was also compared to a wait-list control group. The investigators reported significant improvements in child behaviors in all three treatment groups compared to the wait-list control group. It is interesting to note that the mothers also reported using less spanking as a way to control their children's behavior compared to the control group. Some slight differences were noted between the treatment groups; the group discussion plus videotape group was the only one to decrease parental stress levels and increase praise statements. Also, consumer satisfaction scores and attendance rates were higher for this group. However, the other two programs yielded similar results to the group discussion plus videotape program on other behavioral measures. One of the interesting findings of the study was the self-administered videotape group demonstrated effective results, comparable to the other two training formats along with cost-efficient results, involving no therapist time and only half the time for parents (i.e., videotape viewing vs. group discussion).

In a later study, 100 families with children 3 to 8 years of age who exhibited conduct problems were assigned randomly to a self-administered videotape intervention group or a wait-list control group (Webster-Stratton, 1992). The parents in the treatment group watched a series of 10 videotapes based on cognitive social learning theory and read accompanying manuals that outlined the salient aspects of the vignettes on the videotape and provided weekly homework assignments. The videotapes were

administered to the parents by a secretary and the families had no contact with a therapist during treatment. The parents within the treatment group reported an improvement in children's behavior compared to the control group and an improvement in parent-child interactions. They also reported using less physical punishment in response to their children's behavior. These positive results were maintained during the 1-year follow-up. As can be seen from the Webster-Stratton research, parents can have a significant influence on their children's conduct problems by learning behavioral techniques through a videotape program alone. Since professional time constraints have had an impact on what types of parent training formats can be effectively and efficiently implemented, the research in the area of self-administered, effective parent-training has contributed to the applied research base.

In light of this knowledge base, investigating the effectiveness of self-administered parent and teacher training materials by providing a comparison study to the Rotto-Kratochwill, manual-based and Webster-Stratton studies and by broadening some of the research questions is an area that can provide significant information for consultation research and practice.

As mentioned earlier, research in the area of adult training has focused mainly on parent training formats (Elliott & Busse, 1993), whereas research in behavioral consultation has primarily been conducted with teachers within the school setting (Sheridan, Kratochwill, & VanSomeren, 1988). Using a conjoint behavioral consultation model can promote successful interventions by involving both the teacher and parents in implementing similar treatments across settings (i.e., home, school and community), which broadens the focus of the existing research base. Sheridan,

Kratochwill and Bergan (1995) reviewed the literature in the area of conjoint behavioral consultation. They focused on outcome research investigating the effectiveness of conjoint behavioral consultation and also reviewed case studies. Based upon their review, they concluded that additional consultation with parents and teachers enhances traditional intervention strategies by improving treatment outcomes for students who have both social behavioral difficulties and academic performance problems. They also noted an improvement in the maintenance and generalization of treatment when using a more comprehensive consultation model, such as conjoint behavioral consultation.

In the present study, treatment effectiveness was evaluated and compared between two parent/teacher training formats, a manual-based program and a videotape-based program for reducing children's internalizing and externalizing behavior problems. A conjoint behavioral consultation format (Bergan & Kratochwill, 1990; Sheridan, Kratochwill & Bergan, 1995) was used where parents and teachers were instructed to either read a training manual (the first 2 years of the project) or watch a series of 9 videotapes and read the accompanying manuals during the plan implementation phase (the last 3 years of the program). Phase one of the current study utilized two training manuals developed for internalizing and externalizing behavioral problems. This component of the study was intended to expand the research of the earlier mentioned manual-based studies along with the competency-based behavioral consultation study conducted by Rotto and Kratochwill (1994). It was hypothesized that the manual-based treatment program would produce positive results when comparing children's behaviors within the experimental group to the control group. The second component of this study, Phase two, used the same videotape series developed by Carolyn Webster-Stratton

described in the aforementioned studies. It was hypothesized, similar to the Webster-Stratton studies, that the videotapes would be effective for training parents and teachers to reduce their children's internalizing and externalizing behavior problems. Because of the positive results indicated by Webster-Stratton, it was also hypothesized that the videotape treatment program would show greater behavioral improvement than the manual-based program. In addition to the features noted above, the current study also expands the current knowledge base by adding three additional features. First, the current study involved training teachers along with the parents by using the both program formats; observations of the child were conducted within the school setting along with parental reports of home behaviors. A conjoint consultation format was used to include both parents and teachers in the videotape training program geared for younger children, specifically, preschool-aged children (3-5 years). This component differs from both the Rotto and Kratochwill, and Webster-Stratton studies in that it includes a teacher training focus. Both of the earlier studies centered primarily on parent training techniques.

Second, the current study included children with both internalizing (i.e., withdrawn, depressed) and externalizing behavioral problems (i.e., aggression, noncompliance). The research conducted by Rotto and Kratochwill was directed specifically at managing noncompliant behavior. Similarly, the effectiveness of the videotape series (Webster-Stratton) was studied on conduct disordered children or children who were exhibiting externalizing behavior difficulties. Thus, the current study enhances the research base by including participants who are exhibiting internalizing behavioral difficulties.

Finally, a consultation format was used and individual consultants were assigned to each child. Consultants provided parents and teachers the manuals or videotapes and provided only minimal instructions for viewing the tapes or reading the training manuals. However, the consultants were available to provide additional guidance if needed or warranted. This format differs from the Rotto and Kratochwill study in that the consultant provided direct training on a weekly basis, whereas in the current study the consultants served as minimal contact therapists. The aspect of a minimal contact therapist is more similar to the research described in the Webster-Stratton studies where the videotapes were self-administered with no contact from the consultants, and thus, the treatment group can be compared to the videotape training group described in the Webster-Stratton research.

Overall, the current study also enhanced the research base on the effectiveness of conjoint behavioral consultation. Sheridan and Kratochwill (1992) outlined the specific areas in need of research in this particular area of consultation and important aspects of investigation to include in consultation projects. This study contributed to many research areas outlined, including; (a) providing experimental control, (b) conducting follow-up data, (c) using direct observations, (d) assessing broad-based behaviors, (e) examining teacher/parent perceptions of treatment outcomes, (f) analyzing teacher/parent acceptance of treatment, (g) monitoring treatment integrity for the consultant and consultees.

Chapter II

Literature Review

Conjoint Behavioral Consultation

Conjoint behavioral consultation has been defined by Sheridan et al. (1995) as a systematic, indirect form of service-delivery, in which parents and teachers are joined to work together to address the academic, social, or behavioral needs of an individual for whom both parties bear some responsibility. Conjoint behavioral consultation is similar to behavioral consultation with the exception that it includes two consultees (e.g., parent and teacher) instead of one consultee. Bergan and Kratochwill (1990) describe behavioral consultation as an indirect service delivery system, in which the consultant (e.g., psychologist, therapist) provides consultation services to a consultee (i.e., parent, teacher) to promote a behavior change in the client (i.e., child).

Behavioral consultation is composed of four stages, which are guided by three structured interviews. The first stage, Problem Identification, consists of a structured interview to define the behavior of concern in behavioral terms and to functionally analyze the behavior. Data collection techniques are determined and started at this point. Problem Analysis is the second stage of consultation, in which the problem behavior is further analyzed utilizing the baseline data in the second structured interview. Behavioral goals also are discussed and a treatment plan is developed. The third stage, Treatment Implementation, is the stage when the treatment is started and progress monitored. Finally, the Treatment Evaluation stage consists of the third structured interview determining the effectiveness of the treatment, and discussing the maintainence and generalization of the behavior.

The research conducted on behavioral consultation in the past has demonstrated positive outcomes. Medway reviewed 29 school consultation studies in 1979 and concluded that behavioral consultation was somewhat effective in 76% of the studies (e.g., study reported at least one positive effect). However, he noted many methodological limitations including, lack of experimental control procedures, few multiple measure of behaviors and attitudes, and absence of follow-up data. Medway and Updyke (1985) conducted a meta-analysis on 54 consultation outcome studies that used either health, organization development, or behavioral models. They reported that consultation services seemed to have an effect on both consultee and client behavior and attitudes, with the consultees exhibiting greater positive effects than the clients.

Although researchers have indicated that behavioral consultation is effective in improving children's behaviors, it traditionally has been narrowly focused (Kratochwill, Sheridan, & Van Someren, 1988). Conjoint behavioral consultation can broaden the focus by treating the child's behavior in different settings (i.e., home, school, and community) and with different adult treatment agents. Sheridan and Kratochwill (1992) identified several other goals of conjoint consultation, including: (a) recognition of the need to address problems as occurring across, rather than within settings; (b) joint responsibility for problem-solution; (c) improved communication and interaction among the child, family, and school personnel; (d) a comprehensive and functional assessment of the identified problem; (e) consistency among change agents in behavioral interventions, promoting transfer and maintenance of treatment effects across settings; (f) improved functioning on the part of all parties (i.e., family members, school personnel,

and the child-client); and (g) development of skills and competencies to promote further independent conjoint problem-solving between the family and school personnel.

Several controversial aspects of behavioral consultation recently have been discussed within the literature.

Noell and Witt (1996) discussed five assumptions promoted by behavioral consultation that they argue, are not well supported in the research literature. These assumptions include: "consultation is a superior use of resources when compared to direct intervention, consultation is most effective when conducted collaboratively, talking to teachers is sufficient to cause them to change their behavior, teachers will generalize problem solving skills developed in consultation to new problem situations with other students, and direct contact between the consultant and client is unnecessary" (Noell & Witt, 1996. p. 192). Several areas of criticism of the current consultation research were noted to support these myths. They noted that many studies within the consultation literature lack adequate experimental control and use teacher self-report as the primary dependent measure to indicate client behavior change. Other researchers have commented on the use of teacher perceived (e.g., self-report) effectiveness of client behavior change as being inadequate to directly observing the child behavior (Watson, Sterling, & McDade, 1997). Noell and Witt also question the use of verbal directions to the consultee as being a sufficient mode of training for the teachers to generalize behaviors to the actual classroom environment. It appears that a stronger method of training the consultee may be needed to help the generalization process, along with actually monitoring the consultee's skill level and delivery of behavioral techniques within the classroom setting.

The research in behavioral consultation has focused mainly on teacher or school-based consultation. Few structured models of parent consultation are available in the literature and current studies are methodologically flawed. For example, Cobb and Medway (1978) compared 24 studies focusing on parent consultation to identify variables related to positive outcomes. They reported the majority of the research is methodologically flawed. Becher (1986) reviewed the research on parent involvement and participation in their children's education and found this to be an important component in promoting behavior change, positive attitudes toward the school, and improving parent-child relationship variables. Therefore, a review of the literature on parent training and consultation research is in the following section.

Parent Training

It is well documented that parents can be taught to effectively change the behavior of their children (Henry, 1981; Johnson & Katz, 1973; Kramer, 1990; O'Dell, 1974; Reisinger, Rotto & Kratochwill, 1994; Ora & Frangia, 1976). During the past 20 years, using parents as change agents for their children has increased. Correlated with the increase of parents performing change agent roles are (a) personnel shortages, (b) the questionable effectiveness of traditional treatment methods, and (c) the increased use of other paraprofessionals (e.g., teachers) as change agents (Reisinger et al., 1976).

There are several reasons why parent training can be an advantageous treatment method. First of all, parents develop child rearing skills that can be applied to other siblings and/or future problems with a child (Johnson & Katz, 1973; McLoughlin, 1982). Also, because parents interact with the child more frequently than others, the likelihood of treatment generalization across settings and time is increased (Koven & LeBow, 1973;

O'Dell, 1974). The short duration of some parent training programs is a cost- efficient method for the professional and provides the capacity to meet other client service needs (Henry, 1981; Johnson & Katz, 1973; Reisinger et al., 1976). Most childhood behavior problems can be remediated through behavioral treatment in the natural environment, most parents can implement the procedures taught, and behavioral training programs often appeal to parents because they are viewed as "common sense" procedures (McLoughlin, 1982). Parent training provides benefits for the school psychologist as well. Some of these advantages are diversification of the school psychologist's role, increased visibility, and an improved professional image (Henry, 1981).

Although parent training has evolved from different theories and consists of various formats, three steps remain consistent for effective parent training. These steps include (a) the parents learn the techniques and modify their own behavior, (b) the techniques are implemented with the child and result in a change in behavior, and (c) the change in behavior generalizes and persists (O'Dell, 1974).

Ollendick and Cerny (1981) discussed the three most common parent training formats; parent consultation, individual parent training, and group training. Parent consultation is an indirect service delivery system in which the parent obtains information about behavioral principles through discussions, reading materials, films, role playing, etc. The primary goals of parent consultation are to provide the parents with behavioral change principles, to improve parent child rearing skills, and to change the child's behavior in the desired direction. Parent training can be provided individually or within groups.

Individual parent training differs from parent consultation in that it provides direct training and supervision to one family at a time (e.g., Forehand & McMahon, 1981). Even though individual parent training utilizes many of the same techniques for educating parents (e.g., reading materials, modeling) it also emphasizes supervised practice sessions with the parent implementing the behavioral procedures. Training sessions are conducted in the clinic or the home; the important factor is including the child in the sessions. This format supplies the parent with realistic practice sessions and gives the therapist the opportunity to provide immediate feedback to the parents (Ollendick & Cerny, 1981).

Group training combines elements of parent consultation and individual parent training (e.g., Olympia, Jenson, Clark, & Sheridan, in press). The goals for group training are to modify both parent and child behavior and to train parents in behavior management skills. Thus, evaluation of both the parent's and child's modified behaviors are important to assess in group training. Also, supervision of the parents practicing the new skills can be provided in either analog or natural situations (Ollendick & Cerny, 1981). Some of the benefits of providing parent training within groups are that it promotes peer interaction and reinforcement and it also is a cost-efficient method regarding professional time (O'Dell, 1974).

Self-Help/Self-Administered Therapies

The use of self-administered treatment programs for child-management problems has been researched infrequently (Kramer, 1990). The current literature on self-help therapies generally focuses on parent-training manuals and books; the research being quite limited compared to the availability of self-help books to the public (Rosen, 1993).

Still, research has indicated that self-help treatments can be effective and efficient means of therapy (Scogin, Bynum, Stephens, & Calhoon, 1990).

A few researchers have examined the effectiveness of parent-training manuals on specific behaviors with little or no contact from the therapist. For instance, a study conducted by Giebenhain and O'Dell (1984) evaluated the effectiveness of a parent training manual in reducing children's fear of the dark. Six families participated in this study. A multiple-baseline design was incorporated to analyze the data. The range of symptoms exhibited by the children included tantrums and the inability to spend the night with friends or relatives to requesting that their bedroom light be left on at night. The parent training manual included these components; reinforcement procedures, verbal self-control skills, and a desensitization technique (i.e., reducing bedroom illumination level). The parents had frequent contacts with the experimenter, but no direct training was provided.

The results indicated that the parents were able to reduce their children's fear of the dark by implementing strategies described by a parent training manual and through minimal therapist contact. During treatment, all children successfully decreased the light intensity in their bedroom and reported little or no fear. Within two weeks, all children were able to remain in their rooms with a very dim night light. Follow-up data were collected on each participant at 3, 6, and 12 months after the treatment was completed. The criterion level reached during treatment was maintained by each participant (Giebenhain & O'Dell, 1984).

Two other studies examined the effectiveness of written materials in training parents to correct their children's inappropriate mealtime behaviors. The first study by

McMahon and Forehand (1978), involved the delivery of written materials to three families whose children were misbehaving at the dinner table. The inappropriate behaviors were not specified for the children, but they may have included playing with food, throwing food, leaving the dinner table, etc. The training manual contained instructions for giving praise statements, directive commands, and time-out. Data were collected by independent observers within the participants home during mealtime.

Using a multiple baseline design across subjects to analyze the data, McMahon and Forehand (1978) reported successful results for each family. Inappropriate mealtime behaviors were reduced 50% to 80% for each child. Also, the behavior change for each child was maintained at a 6-week follow-up observation. McMahon and Forehand also examined parental behavior change. The parents appropriate use of reinforcement and punishment procedures improved during the treatment and were maintained at the 6-week follow-up.

The second study that examined the effectiveness of a parent training manual focused on inappropriate behaviors during pre-meal time (Bauman, Reiss, Rogers, & Bailey, 1983). Nine families participated in the study and were randomly assigned to three groups. Each family was videotaped in a restaurant and data were collected by observers who later viewed the tape. The parent training manual provided to the parents emphasized the importance of praise for appropriate behavior and included ways to help the parents restructure a restaurant environment. A group design was used to determine the effectiveness of treatment.

Eight of the nine families obtained successful results in decreasing their children's inappropriate mealtime behaviors (Bauman et al., 1983). Also, at a second restaurant, the

children's inappropriate behaviors remained below baseline, which suggested that the parents were able to generalize the information from the training manual to a new setting. Parental behavior was also examined. Although the parents decreased their use of disapproval statements, they did not increase their use of praise statements. This finding suggested that some procedures described in a parent training manual may be difficult for parents to implement without more thorough training.

Another study that examined the effectiveness of a parent training manual was conducted by Clark, Greene, Macrae, McNees, Davis, and Risley (1977). This study focused on children's problematic behaviors during family shopping trips. Six families participated in the study. Observations of actual shopping trips were conducted and analyzed in a multiple-baseline design across families. After the baseline observation, parents were given a written manual that contained (a) an explanation of a response-cost system and (b) an enhancement component which encouraged the parents to conduct conversations about shopping and other topics to engage their children in the activity. Treatment observations were conducted with the families during shopping trips after the parents had read the manual.

Clark et al. (1977) reported positive results in that the parents increased their social and educational comments and the children decreased distracting behaviors. Therefore, it seems that the parent training manual was effective in reducing children's inappropriate behaviors during shopping trips when used alone.

Children's fighting behavior was an area targeted for remediation through a parent training manual (Sloane, Endo, Hawkes, & Jenson, 1990). Sixteen families participated in this study. A multiple-baseline design across three treatment programs; fighting and

two others, was used to analyze the data. Parents recorded their children's fighting behavior on a daily basis. The treatment program consisted of providing the parents with written materials that emphasized behavior modification techniques organized in a "cookbook" form.

Sloane et al. (1990) reported mixed results. The parents' daily record indicated improvements in 12 of the 16 families. However, at the conclusion of the experiment, parents completed a satisfaction rating scale, which indicated that all of the families had improved. This finding suggests that the parents were satisfied with the program even though their children's behaviors did not significantly improve. Also, it seems that parent training materials can be helpful and effective for some families in reducing children's fighting behaviors.

Similar to the previous study, Endo et al. (1991) conducted a study in which a parent training manual was found to be effective in teaching parents to reduce their children's tantrums. Ten families participated in this study in which a multiple-baseline design across three problem areas was used: tantrums and two other identified problems. The training manuals used were geared for each specific problem area and were presented in a "cookbook" form. Basic behavior modification techniques were outlined in these written materials. The parents did not receive any professional help in implementing the procedures outlined in the manual. The parents recorded behavior on a daily basis which was used as the main outcome measure.

Endo et al. (1991) also reported mixed results. Although parent satisfaction ratings indicated nine out of 10 children improved, the actual parent daily measures showed a decrease in tantrums in only 6 of the 10 children. One out of the four children

who did not improve showed an increase in tantrum behavior during treatment. Although there are mixed results, some families seem to benefit from parent training manuals with no therapist contact.

It should be noted that the studies reviewed above did not include children with severe behavioral problems or atypical children. All of the behaviors targeted for remediation were very discrete behaviors with the manuals focusing on the specific behavioral issue. Also, most of the families involved in these studies were middle class families that were relatively well educated. Therefore, these variables should be recognized when interpreting the results of these studies.

It also should be noted that the self-administered manual-based parent training studies reviewed above did not include children with severe behavioral problems or atypical children. All of the behaviors targeted for remediation were very discrete behaviors with manuals targeted for that specific behavior. Also, most of the families involved in these studies were middle class families that were relatively well educated. Therefore, these variables should be recognized when interpreting the results of these studies.

Although training through written materials may be appropriate for discrete child behaviors, more encompassing self-administered therapies may be more effective for severe behavior problems. A few researchers have compared the effectiveness of written materials to other parent training techniques and have shown that written materials are generally less effective than other training formats. For example, Nay (1975) evaluated the effectiveness of four different training formats on teaching mothers time-out procedures: written presentation; lecture presentation, videotaped modeling presentation;

and modeling and role-playing presentation. A no-treatment control group also was included in this study. Two measures were used to evaluate the effectiveness of training. First, an 18-item questionnaire addressing the time-out instruction was completed by the mothers to assess their knowledge of time-out procedures. Second, an analogue situation which required the mothers to apply the procedures of time-out was observed to evaluate their skill level. Nay (1975) found no significant difference between treatment conditions using the time-out questionnaire data. Also, all treatment groups performed better than the control group on this measure. However, the videotaped modeling and modeling/role-playing groups performed significantly better in the analogue situation than both the written and lecture presentation groups. These results indicate that although the knowledge of time-out procedures was adequately taught in all groups, the skill level needed to implement these procedures correctly was lacking in groups taught by written and lecture presentations.

A similar study was conducted by Flanagan, Adams, and Forehand (1979) who compared different training formats for teaching parents time-out procedures. Again, four treatment conditions were assessed; written presentation, lecture presentation, videotaped modeling presentation, and role-playing presentation. This study also included a no-treatment control group. Similar evaluative measures used by Nay (1975) were adopted to compare the treatment groups, with the addition of a home observation. The results of this study were comparable to the previous study. All treatment groups were superior to the control group on the questionnaire and analogue performance. Again, the treatment groups were equally effective in training the parents when evaluated by a time-out questionnaire. However, there was a significant difference between the

modeling, written presentation, and no-treatment control groups when assessed by demonstrating the skill within their own home, with the modeling presentation group producing better performance on time-out skills.

Another study allowed comparison of the effectiveness of different training formats for teaching parents to use time-out (O'Dell, Krug, Patterson, & Faustman, 1980). In this study, the effectiveness of parent training was assessed through a questionnaire and a home observation. In contrast with the previously mentioned studies, these authors found no significant differences between the training methods of a written take-home manual, a film plus take-home manual, or individual modeling and rehearsal plus a take-home manual. However, each instructional group performed superior to a no-treatment control group in both areas of knowledge and skill level. These conflicting results may be due to the fact that the parents were allowed to take the written materials home, whereas in the previous studies, parents did not take the materials home. O'Dell et al. (1980) hypothesized that parents may forget the procedures that are taught within a clinic. Thus, the take-home written materials may have been equally effective because they were immediately available for the parent to use as a reference when implementing time-out procedures within the home. Similar results were obtained in an investigation of four different parent training formats for teaching reinforcement skills (O'Dell, O'Quin, Alford, O'Briant, Bradlyn, & Giebenhain, 1982).

Another study allowed assessment of six different training models in teaching parents time-out procedures: no treatment, written manual, film, film plus individual supervision, individual training including modeling and rehearsal, and brief individual training and rehearsal (O'Dell, Mahoney, Horton, & Turner, 1979). Each parents' skills

in correctly using time-out procedures were assessed through a structured time-out role-playing procedure. Each treatment method produced better results than the control group, with the film plus individual supervision group obtaining superior understanding and skill level in the analogue situation. Although the parents trained through a written manual performed better than a control group, they did not perform as well as the film or film plus individual supervision groups.

It seems logical that studies comparing the effectiveness of different parent training formats would find the most encompassing methods the most effective. Also, providing parents with direct practice and professional supervision for obtaining change in behaviors would reasonably seem more effective than providing them with written materials. Altogether, research supports this conclusion.

Videotape presentation is a current avenue of parent training and could be a popular method of training parents and teachers in the future. Only a few researchers have examined the efficacy of parent training through videotape presentations. Webster-Stratton (1992) investigated the effectiveness of an individually administered videotape modeling parent training program for children's conduct behaviors. One hundred families participated and were randomly assigned to a treatment or waiting-list control group. Her results indicated that the parents trained through a self-help model (i.e., videotape) demonstrated disciplinary improvement along with improved child behavior. These results are consistent with three similar studies that utilized self-administered videotapes and examined various levels of therapist contact (e.g., Webster-Stratton, 1990; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). It is interesting to note that a minimal therapist contact condition

seemed superior to a self-administered treatment with no therapist contact (Webster-Stratton, 1990). In this study, the researcher investigated the use of therapist's time by audiotaping consultation sessions and found that... "the therapist time was spent in a collaborative consulting role...'fine tuning' the parents' learning...reinforcing their own ideas" (p. 490). This study was similar to the minimal therapist contact condition of the Webster-Stratton study. Consultants took on a supportive role to the parents and teachers learning the behavioral methods through the videotape series. Consultants were able to guide the parents and teachers, answer questions, and monitor their progress through the program.

In summary, there is a need for further research in the utility of parent training methods. There is an abundance of self-administered materials available to the public, but a lack of empirical research on the effectiveness of these materials. Research on parent training techniques is needed in the areas of special populations, minimal professional contact, and with various behaviors ranging in severity. Research also is needed to validate the existing parent training videotapes currently used by professionals and available to consumers. Although direct training has proven to be the most effective parent training method available for most circumstances, a self-instructional approach, even if only implemented with educated families and for less severe problems, would be a cost-efficient approach (Sloane, et al., 1990).

Chapter III

Purpose of Study and Research Predictions

The primary purpose of the present study was to evaluate the effectiveness of two conjoint consultation treatment packages for preschooler's behavioral problems. Specifically, parents and teachers were asked to implement the procedures explained through a parent training series either consisting of a manual-based treatment or a videotape series and manuals (developed by C. Webster-Stratton) in addition to meetings with a consultant. Parents were randomly assigned to a treatment group or a no-treatment control group. A pretest-posttest, experimental-control group repeated measures design was the primary experimental method for this study.

Research Questions and Predictions

Six research questions and related predictions were tested in this study:

1. Are the manual-based and videotape-based programs effective in improving parents' and teachers' perceptions of children's behavioral difficulties and did the two treatment approaches differ in effectiveness?

a) It was hypothesized that parents' perception of their child's behavioral problems and competencies (as measured by the CBCL), ratings of social skills and problem behaviors (as measured by the SSRS-P) utilizing post treatment phase scores would significantly differ between groups (experimental vs. control) and between treatments (manual vs. videotape), with the experimental group and videotape treatment group receiving more positive results compared to the no-treatment control and manual-based treatment groups.

b) It was predicted that teachers' perceptions of students' behavioral problems and competencies (as measured by the TRF), ratings of social skills and problem behaviors (as measured by the SSRS-T) utilizing post treatment phase scores would significantly differ between groups (experimental vs. control) and between treatments (manual vs. videotape), with the experimental group and videotape-based treatment group receiving more positive results when compared to the no-treatment control and manual-based treatment groups.

2. Did the manual-based and videotape-based programs *demonstrate improvement* of children's target behaviors assessed through the direct behavioral observations and parent/teacher reports of goal attainment?

a) It was hypothesized that the manual-based and videotape-based treatment programs would demonstrate an improvement in children's target behaviors assessed through a comparison of the baseline and treatment phases of the direct behavioral observations.

b) It was predicted that the manual-based and videotape-based treatment programs would demonstrate that behavioral goals were achieved through parent/teacher reports of goal attainment.

3. Was there a *difference* between the manual-based and videotape-based programs on the improvement of targeted behaviors assessed through direct behavioral observations and parent/teacher reports of goal attainment?

a) It was hypothesized that direct observations of the target behaviors at baseline and during treatment (measured by an effect size) and the parents' and teachers' reports

on goal attainment would significantly differ between the two treatment groups (manual vs. videotape), with the videotape treatment group producing better results.

The first three predictions were based on past research conducted by Webster-Stratton (1992) in which the videotape series was considered successful when administered to parents of younger children. Success was measured by maternal daily observations and parent-child interactions, along with mother/father self-report measures. In the current study, a pretest-posttest experiemental-control group repeated measures design was used to evaluate the effectiveness of the manual-based and videotape-based programs. Parent and teacher pretest-posttest scales, along with independent observations within the school setting, were the primary outcome measures used repeatedly to assess the children's targeted behaviors. Parent and teacher goal attainment scale (GAS) ratings also were used to assess a change in target behavior and the effectiveness of the treatment program.

4. Did the parents and teachers report that the manual-based and videotape-based programs were effective, acceptable, and satisfactory and did the two interventions (manual and videotape) differ on these dimensions?

a) It was hypothesized that the parents and teachers would report overall satisfaction, acceptability, and effectiveness with both the manual-based and videotape-based treatment programs.

b) It was predicted that there would be a difference between the treatment groups (manual vs. videotape) on the parents' perceptions of overall satisfaction, acceptability, and effectiveness of the intervention program, with the videotape treatment group receiving better scores.

c) It was hypothesized that there would be a difference between the treatment groups (manual vs. videotape) on the teachers' perceptions of overall satisfaction, acceptability, and effectiveness of the intervention program, with the videotape treatment group receiving better scores.

Sheridan and Kratochwill (1992) outlined the importance of evaluating parent and teacher satisfaction with consultation services; both to enhance the knowledge base and to change applied practices. These predictions were tested by parent/teacher completion of the Parent/Teacher Consultation Satisfaction Questionnaire (PTCSQ) and the Treatment Evaluation Inventory-Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989). These questionnaires focus on program satisfaction and perceived effectiveness. Results were provided using descriptive statistics.

5. Did the parents and teachers reported responses to their children's behaviors differ after participating in the videotape treatment program?

a) It was hypothesized that the parents would demonstrate differences between their reported responses to their children's behaviors before and after the intervention program.

b) It was predicted that the teachers would demonstrate differences between their reported responses to the student's behaviors before and after the intervention program.

This prediction was based on past research conducted by Webster-Stratton (1992) using the same scale to demonstrate positive changes in teacher's and parent's behavioral responses to their children.

6. Did the level of reported treatment integrity by parents and teachers have a positive relationship to the videotape treatment outcome?

a) It was hypothesized that parent and teacher reports of treatment integrity (i.e., reports of watching the videotapes and participating in the weekly exercises) would correlate positively with effect sizes of the direct observations.

This prediction investigates the relationship between treatment integrity, a self-report measure completed by parents and teachers, and the level of treatment effectiveness.

Chapter IV

Method

Overview of General Procedures

This study was part of a 5-year research project conducted through the University of Wisconsin-Madison, titled "An Experimental Analysis of Teacher/Parent Mediated Interventions for Preschoolers with Behavioral Problems." During the first two years of the project, the consultation process featured a manual-based approach to treatment implementation. The last 3 years of the project focused on a videotape series as the main treatment component within consultation. This study compared the effectiveness of the two conjoint behavioral consultation programs (i.e., manual-based and videotape-based) on improving preschool children's behaviors and/or social skills. Each treatment group also was compared to a no-treatment control group. The section that follows includes a description of the participants, procedures, instrumentation, experimental design, and data analysis for this study.

Participants and Selection Procedures

Children. The primary participants involved in this study were 123 preschool children attending Wisconsin's Dane County Head Start Program who were identified as experiencing significant behavioral problems. The selection process included children who exhibited behavioral difficulties within two domains, either externalizing (e.g., aggressive, noncompliant) or internalizing (e.g., withdrawn, depressed) behavior problems. Dane County Head Start serves a large number of diverse families; 48% of the families are minorities, including African Americans, Hispanics, Southeast Asians and Native Americans. Ninety-six percent of the families also are below the 100% poverty

index and 60% are single parent homes. The pool of identified participants was assigned randomly to a treatment or no-treatment control group. Participants were identified during initial Head Start screening or through teacher referral.

Demographic information. Information was obtained for the Head Start students involved in this study. Out of 125 child participants, the average age during the beginning pretreatment stage was 4 years, 4 months old. Seventy percent of this population were male participants, with 30 percent being female. Fifty-four percent of the participants were identified as minorities and 78 percent of the participants came from single-parent homes. The experimental group consisted of 68 participants, 25 received treatment during the first two years of the project (manual-based) and 43 received treatment during the last 3 years of the project (videotape-based). From this group of experimental subjects, 62 of them were classified as having primarily externalizing behavioral problems, while only six of them were classified as having internalizing behavioral difficulties. Twenty-one participants composed the no-treatment control group and 23 students dropped out of the program before the post-treatment scores could be obtained. There was insufficient data collected on six participants and seven participants did not qualify for this study, after collecting initial data on these participants. Table 1 provides a description of participants by group.

Consultees. Both teachers and parents served as consultees in this project. Teachers were recruited from Head Start based upon referrals and the initial screening information. Parents were invited and encouraged to participate in the consultation

Table 1

Participants in Study by Group

	Internalizing	Externalizing	Insufficient Data	Totals
Manual Treatment				
Experimental	4	21	0	25
Control	5	5	0	10
Dropped	3	8	1	12
Did Not Qualify	0	0	7	7
Insufficient Data	0	1	1	2
Videotape Treatment				
Experimental	2	41	0	43
Control	1	10	0	11
Dropped	1	9	1	11
Insufficient Data	0	0	4	4

process. The parents were contacted initially through their child's Head Start teacher and then by the consultant. Thirty-six Head Start teachers participated in the project; many of them serviced more than one student during the course of this project and some participated in this project with up to 10 different students. Of the thirty-six Head Start teachers, only 2 of them were male. However, the male teachers participated as consultees in 14 of the cases completed in this project.

Consultants. The consultants for this study were 17 advanced graduate students in the School Psychology Program at the University of Wisconsin-Madison. Fifty-nine percent of the consultants were female and all of the consultants were of caucasion decent. Consultants were trained and experienced in the consultation process. Specifically, they were trained in consultation through a federally funded training and research project and had provided consultative services to teachers having difficulties with children's academic and behavior problems in the classroom. The consultants also had experience working with minority families or with lower socioeconomic status families within the Head Start system.

Participant consent. Parents and teachers were informed of the nature of the research before participating in the consultation project. Their participation was voluntary, and they could discontinue services at any time. Both parents and teachers signed permission forms for screening and consultation services, stating the general nature of the project and possible risks involved. Parent/Teacher consent forms can be found in Appendix A.

Participant screening. Parents completed the Child Behavior Checklist and Social Skills Rating Scale during the Head Start screening process conducted at the beginning of

each school year for the duration of this project. Children eligible for this study were assigned randomly to an experimental treatment or no-treatment control group. Children's behaviors also were categorized at this time as being either primarily externalizing or internalizing. Data gathered from the screening process and also the target behaviors chosen by parents and teachers were used to make this categorical decision.

Observers. Observers were trained to use a systematic observational system developed for the Parent/Teacher Intervention Project. Specifically, the observers were trained to use a 20-second interval recording method that allowed assessment of either positive, neutral, or negative social engagement and particular target behaviors. Observers were trained until they reached 80% interrater agreement; determined by dividing the number of similarly coded intervals by the total number of intervals multiplied by 100. Interrater reliability was maintained at an average of 92% through the five years of the research project. Particular target behaviors were determined during the initial consultation interview with both the treatment and no-treatment control groups and the consultants shared the definition of the target behavior with the observers. The observers were blind to the status of the experimental groups. Observation protocols can be found in Appendix B.

Settings. Most interviews were conducted within the Dane County Head Start sites in Madison, Wisconsin or within the parents home. Parents and teachers were provided videotapes to view within their homes or at the Head Start sites. Observations were conducted within the Head Start classrooms.

Data Collection

The present study used frequent measurement across all phases including subject selection, baseline, program implementation, and treatment evaluation. The frequency of administration of specific assessment measures is provided in Table 2, while Table 3 lists specific assessment procedures, respondents, and estimated time for completion.

Baseline data were obtained to document parent and teacher perceptions of the child's behavioral problem and/or social skill difficulties. Each child's target behavior(s) and level of social engagement were measured repeatedly throughout the intervention phases and was enhanced by multiple observers (i.e., parents, teachers, and observers) and multi-method assessments (i.e., behavioral interviews, rating scales, checklists, and observations). The specific measures included are: the Child Behavior Checklist (CBCL) and Teacher Report Form (TRF) (Achenbach, 1991), the Social Skills Rating System - Parent and Teacher Forms (SSRS-P, SSRS-T; Gresham & Elliott, 1990), the Treatment Evaluation Questionnaire-Parent and Teacher Forms (TEQ-P, TEQ-T), Goal Attainment Scaling (GAS), Treatment Integrity Scales, Responding to Children's Behavior Checklist (RCB), the Parent Consultation Services Questionnaire (PCSQ), and the Teacher Consultation Services Questionnaire (TCSQ). Each measure is described below along with a description of the behavioral interviews and observational system.

Behavioral Checklists and Rating Scales

Child Behavior Checklist. The Child Behavior Checklist (CBCL; Achenbach, 1991) is a 138-item behavioral rating scale designed to be completed by parents of children between the ages of 4 and 18 years (see Appendix C). Administration of the

Table 2

Assessment Methods and Frequency of Administration

Method	Screen	Pre-Tx	Tx Imp	Tx Ev
Observations		X	X	X
BC Interviews		X	X	X
CBCL	X			X
TRF	X			X
SSRS-P	X			X
SSRS-T	X			X
GAS			X	X
Treatment Integrity Checklist				X
RCB		X		X
TEQ-P				X
TEQ-T				X
PCSQ				X
TCSQ				X

Note. Screen = Assessments completed for subject selection purposes; Pre-Tx = Assessments conducted prior to treatment; Tx Imp = Assessments conducted during treatment implementation; Tx Eval = Assessments conducted at the time of treatment termination BC Interviews = Behavioral Consultation Interviews; CBCL = Child Behavior Checklist; TRF = Teacher Report Form; SSRS-P = Social Skills Rating System - Parent; SSRS-T = Social Skills Rating System - Teacher; GAS = Goal Attainment Scaling; Treatment Integrity Checklists = Parent and Teacher Forms; RCB = Responding to Children's Behavior; TEQ-P = Treatment Evaluation Questionnaire - Parent Form; TEQ-T = Treatment Evaluation Questionnaire - Teacher Form; PCSQ = Parent Consultation Services Questionnaire; TCSQ = Teacher Consultation Services Questionnaire.

Table 3

Assessment Plan

Phase	Assessment Procedure	Respondent Estimate	Time to Complete
Screening	CBCL	parent	17 min
	TRF	teacher	17 min
	SSRS-P	parent	20 min
	SSRS-T	teacher	20 min
Problem Identification	Interview	parent/teach	60 min
	Observations	observ/teach	30 min
Problem Analysis	Interview	parent/teach	60 min
	Treatment Int	parent/teach	3 min
	Observations	observ/teach	30 min
	RCB	parent/teach	5 min
Plan Implementation	Read Manual	parent/teach	variable
	View Videos	parent/teach	variable
	Observations	observ/teach	30 min
	GAS	parent/teach	3 min
	Treatment Int	parent/teach	3 min
Treatment Evaluation	Interview	parent/teach	60 min
	Observations	observ/teach	30 min
	CBCL	parent	17 min
	TRF	teacher	17 min
	SSRS-P	parent	20 min
	SSRS-T	teacher	20 min
	TEQ-P	parent	7 min

Table 3 (continued)

Phase	Assessment Procedure	Respondent Estimate	Time to Complete
	TEQ-T	teacher	7 min
	RCB	parent/teach	5 min
	PCSQ	parent	7 min
	TCSQ	teacher	7 min

Note. CBCL = Child Behavior Checklist; TRF = Teacher Report Form; SSRS-P = Social Skills Rating System - Parent; SSRS-T = Social Skills Rating System - Teacher; Interview = Behavioral Consultation Interviews; RCB - Responding to Child Behavior Checklist; GAS = Goal Attainment Scaling; Treatment Int = Treatment Integrity; TEQ-P = Treatment Evaluation Questionnaire - Parent Form; TEQ-T = Treatment Evaluation Questionnaire - Teacher Form; PCSQ = Parent Consultation Services Questionnaire; TCSQ = Teacher Consultation Services Questionnaire.

CBCL is straightforward and takes approximately 15 to 20 minutes to complete. Separate norms are available for males and females at ages 4-5, 6-11, and 12-18 years. The CBCL consists of two different scales; the Social Competency Scale and the Behavior Problems Scale. The Behavior Problems Scale was utilized as a screener for severe behavioral problems in this study.

The Behavior Problems Scale consists of 118 items which are rated on a 3-point scale (i.e., not true, somewhat or sometimes true, and very or often true). The list of items on this scale include observable child behaviors (e.g., destroys own things), behaviors that include some parental judgment (e.g., depressed), and behaviors that require considerable parental inferences (e.g., feels worthless or inferior).

A total problem behavior index is obtained through the completion of the Behavior Problems Scale. This index has been found to be a useful discriminator between disturbed and nondisturbed children. Two broad-band factors, Externalizing Syndrome and Internalizing Syndrome, are obtained from this scale. The Externalizing Syndrome includes problem behaviors such as hyperactivity and aggression, whereas the Internalizing dimension includes behaviors such as anxiety and depression.

Careful attention to psychometric detail is a strength of the CBCL. The CBCL has adequate reliability and validity as examined in the manual through various studies. Achenbach (1991) examined the test-retest reliability for the total problem behavior index and reported it as a high stability coefficient of .89. The CBCL manual also presents a great deal of evidence for content, construct, and criterion-related validity. In regard to criterion-related validity, the author reports moderate to high correlations (.59-

.81) between the CBCL and the Conners Parent Questionnaire Scale (Conners, 1973) and the Revised Behavior Problem Checklist (Quay & Peterson, 1983).

Normative data for the CBCL were based on a sample of 2,368 children between the ages of 4 and 18 years. This standardization group was relatively representative of socioeconomic groups. Parents completed the CBCL during the pre-treatment and treatment evaluation phases.

Teacher's Report Form. The Teacher's Report Form (TRF; Achenbach, 1991) is a scale intended for teachers to complete to describe children's behavior relative to their same-age peers (see Appendix D). The TRF is modeled after the CBCL and consists of 118 items related to behavioral problems seen within the school. Two broad band factors are also included on the scale that parallel the CBCL, "externalizing" and "internalizing" syndromes. The TRF is an adequately reliable and valid measure of children's behavior. Test-retest reliabilities ranging from 1 to 4 weeks between ratings were reported to be .90 to .92 correlation. Teachers completed the TRF during the pre-treatment and treatment evaluation phases.

Social Skills Rating System - Parent and Teacher Forms. The Social Skills Rating System - Teacher Form (SSRS-T: Gresham & Elliott, 1990; Elliott, Barnard & Graham, 1989; Elliott, Gresham, Freeman, & McCloskey, 1988), is a 40-item rating scale and the preschool level (see Appendix E). The Social Skills Rating System - Parent Form (SSRS-P; Gresham & Elliott, 1986) is a 49-item rating scale at the preschool level (see Appendix F). Both scales measure how often a particular social behavior occurs (never, sometimes, or very often) and how important the parent or teacher views the behavior. The SSRS also provides a problem behavior scale that investigates behavioral

problems within the externalizing and internalizing domains. Both the parent and teacher scales have strong psychometric properties. Internal consistency and test-retest reliability have been reported as being adequate to high. Parents and teachers completed the SSRS-P and SSRS-T during the pre-treatment and treatment evaluation phases.

Goal Attainment Scaling. Goal attainment scaling (GAS) is a method for quantifying the progress made on a specific target behavior to facilitate monitoring of the treatment program. Reliability studies on the GAS have revealed high interrater reliability scores (product-moment correlations of $r = .87$ to $r = .99$) and lower reliability estimates when scoring on different occasions, which is expected when using an instrument to measure change (Kiresuk, Smith, & Cardillo, 1994). Kiresuk, et al., (1994) recommended the GAS as a measure of change induced by a treatment and should not be used as an outcome measure alone.

Goal attainment scales for this study consisted of 5 points, ranging from the worst possible behavior (-2) to the best possible behavior (+2). A score of zero indicates no change with the target behavior (see Appendix G). Teachers and parents identified a specific goal during the Problem Analysis Interview and were asked to complete the GAS on a weekly basis. The mean of the last 2 or 3 GAS scores was used as the final GAS score for each case. This method of reporting GAS scores appears to be most accurate, since most cases would not be expected to reach their stated behavioral goal until treatment was completed or at least implemented. Goal attainment scaling was introduced during the second year of the project.

Treatment Integrity Checklists. During the first two years of the project, treatment integrity data were collected for several cases and was reported in percentages.

During the last three years of the project, parents and teachers completed treatment integrity checklists on a weekly basis. These checklists, which can be found in Appendix I, outline the elements of the videotape-based treatment program and help in the assessment of whether the treatment program was completed as designed; fully, partially or not completed. Consultants used this self-report format to facilitate communication about the program with parents and teachers, and to monitor their progress throughout treatment.

Responding to Children's Behavior Checklist. Responding to Children's Behavior Checklist is a 16-item scale that examines different parent and teacher responses to children's appropriate and inappropriate behaviors (see Appendix I). This scale was used as an indicator of changes in parent and teacher behaviors toward their children before and after viewing the videotape series (i.e., during the last three years of the project). Since parent and teacher behaviors were not being directly monitored, this self-report indicated behavioral change in the consultees. Parents and teachers were asked to complete this scale during the Problem Analysis Interview (PAI) and the final interview (TEI) in the last two years of the project.

Treatment Evaluation Questionnaire - Parent and Teacher Form. The Treatment Evaluation Questionnaire - Parent and Teacher Forms (TEQ-P and TEQ-T) consists of 24-items which evaluate the acceptability, appropriateness, and predicted effectiveness of a specific treatment using a six-point scale. This scale was adapted from the Treatment Evaluation Inventory (TEI; Kazdin, 1980) and developed to assess the reported effectiveness of the treatment by the teacher and the parent. Items on the original TEI were chosen through the process of factor analysis replicated across separate samples

(Kazdin, 1980). Some researchers have suggested that different treatments vary in terms of acceptability and that the TEI can differentiate between these interventions (Kazdin, 1980; Kazdin, French, & Sherick, 1981). Administration of the TEQ-P (Appendix J) and the TEQ-T (Appendix K) occurred during the treatment evaluation phase of this study.

Parent/Teacher Consultation Services Questionnaire. The Parent/Teacher Consultation Services Questionnaires (PCSQ and TCSQ) were developed to assess parent and teacher levels of satisfaction with the consultation program. Specific questions reflecting attitudes toward behavioral consultation, the consultant, and the treatment were addressed. Items for the PTCSQ were adapted from the Parent's Consumer Satisfaction Questionnaire (Forehand & McMahon, 1981) and the Consultation Services Questionnaire (Zins, 1984). Parents and teachers were asked to complete this 7-point likert scale during the treatment evaluation phase of this study. The PCSQ and TCSQ can be found in Appendix L and M, respectively.

Conjoint Behavioral Interviews. The stages of behavioral consultation were the guiding format for this study, which included four phases: problem identification, problem analysis, treatment implementation, and treatment evaluation. The conjoint behavioral interviews were conducted during the problem identification and treatment evaluation phases. During the problem analysis phase, the manual or videotape series was introduced to the teacher and parents instead of conducting the standard problem analysis interview. Specific objectives for the two interviews were developed by Kratochwill and Bergan (1990; see Table 4), and were modified to include questions directed toward the home and school environments (Sheridan, et. al., 1996; see Appendix N).

Table 4

Objectives for Stages of Behavioral Consultation

Stage 1: Problem Identification Interview
General Statement
Behavior Specification
Examples and Precise Description
Specify Priorities
Behavior Setting
Examples and Precise Description
Specify Priorities
Antecedent Conditions
Sequential Conditions
Consequent Conditions
Summarize and Validate Conditions
Behavior Strength
Summarize and Validate Behavior and Behavior Strength
Goal Statement
Child Strengths and Assets
Existing Procedures
Summarize and Validate
Rationale for Data Collection
Specific Data Collection Procedures

Table 4 (continued)

Summarize and Validate Data Collection
Date to Begin Data Collection
Next Appointment
Stages 2 & 3: Problem Analysis & Treatment Implementation
Distribute Videotapes and Manuals
Teacher/Parents view videotapes and manuals
Implementation of Treatment Outlined in videotape program
Weekly Collection of Data
(teachers, parents, and observers)
Stage 4: Treatment Evaluation Interview
General Question Regarding Outcome
Goal Attainment
Plan Effectiveness/Internal Validity
External Validity
Plan Continuation
Generalization and Maintenance
Follow-up Assessment
Future Interviews
Termination of Consultation

The Problem Identification Interview (PII) was conducted with each parent and teacher to specify the target behavior(s) and to discuss the daily data collection procedure. During the Problem Analysis and Treatment Implementation phases, the parents and teachers were introduced to the method of treatment; the manual was discussed and given to the parents/teachers during the first two years, the videotape series given to the parents/teachers during the last three years of the project. Along with a discussion of the various treatment components, the parents/teachers were also introduced to the GAS procedure at this time. Completing the GAS facilitated the development of realistic goals and allowed development of a progress monitoring system that was directly linked to the stated goal. During the treatment implementation phase, parents and teachers were instructed to read the manuals or view the videotape series and to implement the child management procedures explained in them. Finally, the Treatment Evaluation Interview (TEI) was conducted to determine the effectiveness of the consultation program on improving children's social skills and behaviors.

Procedure

Screening. Children qualified for consultation services by obtaining scores on the initial screening measures that indicate a significant behavior/social problem (at least 1 standard deviation from the mean) on the CBCL, TRF or SSRS-P/T and through teacher referral. The children were then assigned randomly to a treatment group or no-treatment control group.

No treatment control group. Consultants conducted an initial PII with all children to identify target behaviors for monitoring behavior within the classroom. After determining the children's area of difficulty and defining a target behavior, observers

conducted weekly observations within the Head Start Classroom for the no-treatment control group of children; they were blind to the experimental conditions. These children were referred for alternative services within the community.

Treatment group. Observers conducted weekly observations within the Head Start classroom with this group of children throughout the duration of consultation. Treatment consisted of either a manual-based program or a videotape series on various parenting techniques used for a variety of problem behaviors. The manual-based approach was used during the first two years of the study. The manual-based approach consisted of using one of two manuals that focused on either externalizing behaviors (i.e., conduct problems) or internalizing behaviors (i.e., withdrawal, poor social skills). The child's identified target behavior or problem area was then matched with one of the two manuals. The manuals presented various behavioral techniques to use with preschool children (see Appendix o). Various components in the manuals consisted of behavioral approaches such as setting behavioral goals, rewarding of positive behaviors, ignoring techniques, utilizing time-out procedures, differential attending techniques, etc (see Table 5). Parents and teachers were instructed to read the manuals and implement the procedures outlined in the manuals. Consultants were available for questions, however, the manual treatment generally was considered self-administered.

During the last three years of the project, a videotape series with accompanying manuals was distributed to the parents and teachers involved in the study. The videotape program, developed by Carolyn Webster-Stratton, consisted of nine different videotapes teaching parenting skills in four different areas. The videotape categories are listed in Table 6.

Table 5

Outline of Self-Help Manuals

BEHAVIOR PROGRAM FOR PRESCHOOLERS - PARENT MANUAL

- Setting-up for success
- Skill Selection and Goal Setting
- Child Management
  - Differential Attending
    - Attending
    - Attending and Rewarding
    - Attending, Rewarding, and Ignoring
    - Summary: Putting it all together
  - Instruction Giving
  - Time Away
  - Guidelines for Increasing Your Child's Good Behaviors
- Home-School Communication
- Peer Activities at Home

BEHAVIOR PROGRAM FOR PRESCHOOLERS - TEACHER MANUAL

- Skill Selection and Goal Setting
- Peer Activity at School
- Child Management
  - Differential Attention
  - Instruction Giving
- Time Away

SOCIAL PROGRAM FOR PRESCHOOLERS - PARENT MANUAL

- Skill Selection and Goal Setting
- Peer Activity at Home
- Positive Reinforcement

SOCIAL PROGRAM FOR PRESCHOOLERS - TEACHER MANUAL

- Skill Selection and Goal Setting
- Peer Activity at School
- Positive Reinforcement

Table 6

Webster-Stratton Videotape Series

PLAY PROGRAM
Part 1: How to Play with a Child
Part 2: Helping Children Learn
PRAISE AND REWARDS PROGRAM
Part 1: The Art of Effective Praising
Part 2: Tangible Rewards
EFFECTIVE LIMIT SETTING PROGRAM
Part 1: How to Set Limits
Part 2: Helping Children Learn to Accept Limits
Part 3: Dealing with Noncompliance
HANDLING MISBEHAVIOR PROGRAM
Part 1: Avoiding and Ignoring Misbehavior
Part 2: Time Out and Other Penalties & Preventative Approaches

The first program to be presented to the parents is called the Play Program and consists of two videotapes. The videotapes focus on attending to child directed play and fostering creativity in children. Second, the Praise and Rewards video program is presented to the parents and teachers. This two-part series focuses on praising children's positive behaviors through adult interaction and tangible rewards. Point systems and reinforcement charts are also explained in this section. The third program consists of three videotapes and examines Effective Limit Setting Techniques, such as giving clear and concise commands and describes how to use time-out procedures in response to noncompliance. The final two videotapes present methods for Handling Misbehavior, including time-out procedures and how to ignore inappropriate behavior. Each videotape has an accompanying chapter from the manual that outlines the various vignettes on the tapes. For more detailed information on the videotape series and accompanying manuals, refer to the BASIC parenting program outlined in Webster-Stratton and Hancock (in press), however, note that a group format was not used within this study.

After the parent and teacher completed the manual-based treatment or the videotape series, a Treatment Evaluation Interview was conducted. At this point, it was determined whether the treatments were effective in changing the child's behavioral difficulties.

Consultants generally served three roles throughout the consultation process. First, they collected information about the child's problem through the interviews and various checklists and monitored the progress through the programs for both the parents and the teachers. Second, they distributed the appropriate manuals and videotapes to both the parents and teachers. Third, they provided needed support for both the teachers

and parents involved regarding the various treatments. Thus, they answered questions about the treatments and helped clarify issues regarding the manuals and videotapes. The role of the consultants in this study can be compared to the consultants who served as minimal contact consultants in the Webster-Stratton study (1990). In her study, the consultants answered questions that families had about the videotape series, but did not take an active role in providing training.

Experimental Design

This research study involved single-case and between group outcome research design strategies. The primary research design was a pretest-posttest experimental-control group repeated measures design. As mentioned previously, children were assigned randomly to the treatment group or the no-treatment control group. The control group consisted of children receiving services from the Head Start Organization and possible community services, however, they did not receive services from this project. This type of control condition is common in treatment research from both a methodological and ethical perspective (Kazdin, 1992).

The independent variable in this study was the parent/teacher training via the manual-based or videotape-based series, which were the treatments used during the treatment implementation phase of behavioral consultation. The dependent variables were the children's behavioral outcomes (i.e., behavioral observations and parent/teacher checklists). Evaluation of the two treatment methods occurred through the consideration of four parameters: (a) treatment effectiveness, (b) treatment integrity, (c) treatment acceptability, and (d) social validity (Shapiro, 1987).

Treatment effectiveness. The primary analyses for treatment effectiveness involved the pre-post test experimental control group repeated measures design. Specifically, the pre-post tests (i.e., CBCL, TRF, SSRS-P and the SSRS-T) were analyzed through a multivariate analysis of covariance (MANCOVA), with the pretests serving as the covariate (Stevens, 1996). Standard scores from the SSRS were used within the MANCOVA. However, due to an error in the administration of the CBCL and TRF, z-scores were used in place of standard scores for the CBCL and TRF (inadequate norms were available for 17 cases because of the young age of the students involved in the program). These same pre-post self-report measures also were analyzed through a single-case research design technique referred to as a reliability of change index (RCI; Gresham & Noell, 1993).

The two treatment groups also were compared using a multivariate analysis of variance on the GAS and effect size data. As stated earlier, final GAS scores were obtained by calculating the average of the last 2 or 3 GAS scores reported. Effect sizes were calculated from the observations of target behaviors. Specifically, effect sizes were obtained by subtracting the mean of the treatment phase observations by the mean of the baseline phase and dividing by the standard deviation of the baseline. When there was no variance within the baseline data, a decision was made to combine the baseline and treatment data to determine the standard deviation. Finally, frequency data from the Responding to Children's Behaviors pre-post tests were collected for the videotape treatment group only.

Treatment integrity. Treatment integrity refers to the accuracy with which the specified treatment was implemented. Treatment integrity was assessed on both the

process and content of the study. To ensure that the integrity of the behavioral consultation model was maintained across all phases of this study, all of the behavioral consultation interviews were tape recorded. Kratochwill and Bergan (1990) developed checklists of the essential objectives of each behavioral interview (See Appendix P). The overall percentage of objectives met for a sample of the interviews was reported by randomly sampling one interview per consultant. An overall percentage of 97% of the objectives were met, with a range from 88% to 100%.

The second area of treatment integrity involved the evaluation of the parents' and teachers' implementation of the procedures explained within the videotape series. The parents and teachers were asked to complete a weekly checklist corresponding to the essential objectives of the videotape series (see Appendix H). This self-report measure provided data indicating the occurrence and nonoccurrence of consultee compliance for each component within the videotape series. Percentages were reported.

Finally, the level of treatment integrity was compared to the effect size of the treatment and GAS. Correlational data were reported for the videotape series treatment group alone on these measures.

Social validity. Social validation is an assessment of whether the clients have found the therapeutic changes to be clinically or socially important. The client level of satisfaction with a specific approach is an important variable that contributes to the success of the intervention (Kazdin, 1977). Both parents and teachers were provided rating scales at post-treatment to evaluate the social validity of the methods (i.e., manual or videotape series) and the treatment outcome. The consultees completed the Parent/Teacher Consultation Services Questionnaire (Appendix L or M). An analysis of

variance was conducted on these data to compare the satisfaction level between treatment groups (manual vs. videotape). In addition, results of this questionnaire were reported qualitatively.

Treatment acceptability. Treatment acceptability refers to parents' and teachers' perceptions of whether the procedures are acceptable for the identified problem. The acceptability of the treatment was assessed during the treatment evaluation phase of this study using the Treatment Evaluation Questionnaire - Parent and Teacher Forms (TEQ: see Appendix J and K). Three subscales were calculated from the TEQ which consisted of a measurement of treatment acceptability, effectiveness, and amount of time. On the teacher's scale, items corresponding to the Acceptability scale included items 1 - 14, to the Effectiveness scale items 15, 17-18, 20-24, and to the Amount of Time scale items 16 and 19. On the parent's scale, items corresponding to the Acceptability scale included items 1-11, to the Effectiveness scale items 12, 14-15, 17-21, and to the Amount of Time scale items 13 and 16. A multiple analysis of variance was conducted on this data to compare treatment groups (manual vs. videotape). The results of these questionnaires also were reported qualitatively.

Chapter V

Results

Evaluation of the two treatment methods (manual and videotape groups) versus the control group occurred within the context of testing the research predictions outlined in Chapter III. Rating scales and questionnaires were scored and data entered by several advanced graduate students involved in the consultation project. A reliability check on 20% of the data obtained a level of 97% before the data were analyzed. Several areas that were considered important or crucial to the outcome of the project were fully (100%) checked to ensure accuracy. The results are organized by the research predictions .

Treatment Effectiveness (Questions 1,2 & 3). Treatment effects were evaluated by parent and teacher self-report measures (CBCL, TRF, SSRS) by using both group design and single-case methodologies. Table 7 presents the number of cases, means, and standard deviations for the parent report measures by group. Within the group design format, multivariate analysis of covariance (MANCOVA) was used to evaluate treatment outcomes based on self-report measures (Stevens,1996). Two statistical checks were made to determine whether covariance was appropriate. First, it was determined that there was indeed a significant relationship between the dependent variables and the covariates (i.e., posttests and pretests). A second check also was conducted to ensure that the homogeneity of the regression hyperplanes was tenable. Using the pretest scores as the covariate, the MANCOVA revealed no significant effect for the analysis on parent self-report measures, that is, there was no significant differences found between the adjusted population mean vectors, $F(2,43) = .90$, $p<.48$. The multivariate F score corresponds to Wilks' Lambda. One possible reason that significance was not found

Table 7

Parent Report Measures Before and After Treatment by Group

	Manual			Videotape			Control	
	Pre	Post		Pre	Post		Pre	Post
Report Measure	N M SD	M SD	N	M SD	M SD	N	M SD	M SD
CBCL Total Problem Z-scores[a]	5 1.63 (.69)	1.00 (.51)	10	.52 (.44)	.92 (.85)	2	1.21 (.25)	1.20 (.81)
SSRS Social Behaviors Standard Scores[b]	14 73 (12)	89 (16)	34	81 (15)	85 (13)	11	82 (11)	79 (11)
SSRS Problem Behaviors Standard Scores[c]	14 127 (12)	116 (14)	34	118 (15)	112 (15)	11	121 (13)	116 (14)

Note. CBCL=Child Behavior Checklist; SSRS=Social Skills Rating System.

[a] Higher scores indicate greater behavioral problems.

[b] Higher scores indicate better social skills.

[c] Higher scores indicate greater behavioral problems.

between groups, was that the statistical power was low (.34) due to small group sizes and large variance. Thus, the chances of correctly rejecting the null hypothesis just exceed 3 out of 10.

On the teacher self-report measures, the MANCOVA revealed no significant effect for the analysis on teacher self-report measures, $F(2,60) = .69$, $p<.65$; again the multivariate F score corresponds to Wilks'Lambda. Table 8 presents the number of cases, means, and standard deviations for the teacher report measures by group.

On the teacher report measures, all groups indicated an increase in behavior problems on the CBCL and a decrease in problem behaviors on the SSRS-PBS. Also, each group reported improvement in social skills. Because of this similarity in groups, it would be difficult to detect any differences that would be significant. In addition to a lack of differences in the data, statistical power was low (.27) due to small group sizes and large variance.

Single-case research design methods were used to further analyze the data obtained from parent/teacher self-report measures. Specifically, a reliability change index (RCI) was used to determine the effectiveness of the intervention (Gresham & Noell, 1993) by using pre-post self-report measures (i.e., CBCL, TRF, and SSRS). The RCI was calculated using the pre-post measures for each individual case (pretest minus posttest divided by the standard error of measurement for the given measure; presented in Table 9) and a summary of the RCI data is outlined in Table 10. An RCI of $\pm$ 1.96 is considered statistically significant ($p<.05$).

Table 8

Teacher Report Measures Before and After Treatment by Group

	Manual			Videotape			Control	
	Pre	Post		Pre	Post		Pre	Post
Report Measure	N M SD	M SD	N	M SD	M SD	N	M SD	M SD
TRF Total Problem	8	.93	1.05	10	.94	.99	6	.74	.87
Z-scores[a]		(.41)	(.63)		(.53)	(.70)		(.57)	(.49)
SSRS Social Behaviors	18	86	92	39	85	90	16	86	93
Standard Scores[b]		(11)	(12)		(11)	(12)		(11)	(11)
SSRS Problem	18	118	112	39	114	110	16	112	109
Behaviors		(14)	(12)		(15)	(14)		(12)	(17)
Standard Scores[c]									

Note. CBCL=Child Behavior Checklist; SSRS=Social Skills Rating System.

[a] Higher scores indicate greater behavioral problems.

[b] Higher scores indicate better social skills.

[c] Higher scores indicate greater behavioral problems.

Table 9

Reliability Change Index for Pre-Post Parent and Teacher Measures by Case

Case #	Type of Treatment or Control Group	Parent Measures			Teacher Measures		
		CBCL[a]	SSRS S.S.[b]	SSRS Prob. Beh.[c]	TRF[d]	SSRS S.S.	SSRS Prob. Beh.
Case 2	Control	3.57*	0.40	7.67*	2.30*	-0.86	-1.33
Case 4	Manual	10.37*	-0.78	0.67	7.00*	-2.13*	2.00*
Case 7	Manual	6.47*	-0.20	4.67*	____	____	____
Case 10	Control	____	____	____	-2.13*	-2.29*	-3.00*
Case 13	Manual	____	____	____	-0.33	2.86*	-1.67
Case 17	Control	-4.79*	0.44	0.00	____	____	____
Case 18	Manual	2.46*	-1.10	1.33	-1.97*	-0.86	0.00
Case 19	Manual	-1.34	0.40	0.67	-0.16	-0.29	1.67
Case 21	Manual	____	____	____	-4.50*	-2.88*	5.33*
Case 22	Manual	4.02*	-1.90	4.67*	-2.30*	0.00	0.00
Case 24	Manual	____	____	____	-2.46*	1.71	-0.67
Case 25	Manual	____	____	____	-1.64	-2.57*	1.00
Case 26	Manual	____	-1.20	-2.00*	1.64	-0.29	1.33
Case 27	Manual	____	____	____	17.50*	-4.13*	10.00*
Case 29	Manual	0.00	-0.40	-1.33	2.46*	-2.14*	5.33*
Case 31	Manual	____	____	____	-1.31	0.43	3.33*
Case 32	Manual	____	-3.40*	9.00*	-5.41*	-0.14	-7.33*
Case 33	Manual	9.31*	-4.44*	8.00*	-9.50*	1.13	-1.33
Case 34	Manual	-2.66*	-0.67	-1.33	3.00*	-1.13	0.00

Table 9 (continued)

Case #	Type of Treatment or Control Group	Parent Measures			Teacher Measures		
		CBCL[a]	SSRS S.S.[b]	SSRS Prob. Beh.[c]	TRF[d]	SSRS S.S.	SSRS Prob. Beh.
Case 35	Manual	10.64*	-5.44*	4.67*	9.00*	-2.25*	5.00*
Case 36	Control	____	-0.50	1.67	____	-1.14	6.00*
Case 37	Manual	____	____	____	1.15	-0.43	3.00*
Case 38	Control	-3.57*	1.20	-5.67*	____	____	____
Case 47	Control	____	____	____	1.50	-0.75	5.33*
Case 48	Control	____	0.50	6.00*	2.46*	-3.86*	6.67*
Case 50	Manual	2.23*	-2.20*	9.33*	____	____	____
Case 51	Manual	7.14*	-0.40	5.33*	____	____	____
Case 52	Control	5.85*	____	____	-3.50*	0.38	-2.67*
Case 53	Manual	____	____	____	5.08*	-2.57*	8.00*
Case 54	Manual	5.59*	-1.22	6.67*	____	____	____
Case 55	Control	____	____	____	0.00	-1.88	1.33
Case 57	Videotape	3.72*	-0.44	2.67*	1.50	-0.88	0.00
Case 58	Videotape	6.70*	-2.20*	12.33*	-0.66	-0.43	0.00
Case 59	Videotape	-4.69*	-0.60	-0.67	1.15	-2.86*	2.00*
Case 61	Videotape	-2.90*	-0.60	-1.33	8.03*	-2.29*	10.00*
Case 62	Videotape	2.90*	0.00	0.00	____	____	____
Case 63	Videotape	____	-0.90	0.00	____	-2.71*	6.00*
Case 64	Videotape	____	.89	0.00	____	-0.50	2.33*
Case 65	Control	____	____	____	____	0.43	-2.00*
Case 66	Videotape	2.68*	-1.90	1.33	-7.54*	0.57	-6.00*
Case 67	Videotape	-4.24*	1.10	-3.33*	-3.28*	-1.17	4.33*
Case 68	Control	____	____	____	-5.00*	-0.88	-1.33

Table 9 (continued)

Case #	Type of Treatment or Control Group	Parent Measures			Teacher Measures		
		CBCL[a]	SSRS S.S.[b]	SSRS Prob. Beh.[c]	TRF[d]	SSRS S.S.	SSRS Prob. Beh.
Case 69	Videotape	0.67	-1.90	3.00*	9.67*	-4.00*	3.67*
Case 72	Videotape	2.23*	-0.20	14.00*	5.90*	-1.43	1.00
Case 73	Videotape	-1.79	-1.50	1.67	3.28*	-2.57*	4.67*
Case 74	Videotape	1.79	-0.80	5.67*	0.33	0.29	-1.00
Case 75	Control	-4.02*	0.90	0.00	____	____	____
Case 76	Videotape	____	-1.11	2.00*	____	-1.88	5.00*
Case 77	Videotape	____	____	____	4.75*	-0.29	3.00*
Case 78	Videotape	2.46*	0.10	0.00	0.00	-0.14	-7.33*
Case 79	Control	____	3.10*	1.33	-1.31	-0.14	0.00
Case 81	Videotape	2.90*	-0.90	7.33*	-0.98	0.29	0.00
Case 82	Videotape	-4.79*	0.33	1.33	____	____	____
Case 83	Videotape	-1.34	0.00	2.00*	-7.70*	-0.57	-3.00*
Case 85	Videotape	1.12	0.00	4.67*	-0.98	1.43	1.00
Case 87	Videotape	0.00	-1.78	5.00*	0.50	0.50	0.00
Case 89	Videotape	____	____	____	-2.46*	-1.43	0.00
Case 90	Videotape	-7.98*	2.44*	-9.00*	1.00	1.00	0.33
Case 92	Control	4.46*	-0.90	3.33*	0.00	-1.43	1.33
Case 93	Videotape	3.72*	-0.11	10.33*	0.50	-0.38	1.33
Case 94	Videotape	-0.53	-2.33*	4.67*	-1.00	1.50	-1.00
Case 95	Videotape	3.79*	-2.20*	11.33*	-1.64	-0.43	2.67*
Case 96	Videotape	1.12	-0.20	0.00	0.00	-0.57	0.00
Case 97	Videotape	1.86	-0.11	7.00*	0.50	-0.13	1.33
Case 98	Videotape	____	____	____	-1.00	-1.75	-6.33*

Table 9 (continued)

Case #	Type of Treatment or Control Group	Parent Measures			Teacher Measures		
		CBCL[a]	SSRS S.S.[b]	SSRS Prob. Beh.[c]	TRF[d]	SSRS S.S.	SSRS Prob. Beh.
Case 100	Videotape	____	-1.00	0.00	____	2.71*	-4.33*
Case 101	Control	____	____	____	-4.00*	0.00	-4.00*
Case 102	Videotape	6.25*	-1.20	-2.00*	0.33	-0.29	4.00*
Case 103	Control	____	____	____	____	-0.38	2.67*
Case 106	Control	____	0.11	1.33	7.00*	-0.63	3.67*
Case 107	Videotape	____	____	____	-4.59*	1.00	-2.00*
Case 108	Videotape	11.83*	-2.30*	6.33*	-2.62*	____	____
Case 109	Videotape	-6.25*	____	____	____	____	____
Case 110	Control	-2.01*	-0.60	3.67*	-3.77*	0.43	0.00
Case 111	Videotape	____	____	____	5.08*	0.29	4.67*
Case 112	Videotape	____	____	____	____	-2.88*	11.33*
Case 113	Videotape	____	____	____	8.03*	-0.43	1.00
Case 116	Videotape	1.56	0.00	0.00	3.28*	-0.71	3.33*
Case 118	Videotape	____	____	____	0.50	-2.00*	5.00*
Case 119	Videotape	10.04*	1.00	1.33	-0.66	-1.43	0.00

Table 9 (continued)

Case #	Type of Treatment or Control Group	Parent Measures			Teacher Measures		
		CBCL[a]	SSRS S.S.[b]	SSRS Prob. Beh.[c]	TRF[d]	SSRS S.S.	SSRS Prob. Beh.
Case 120	Videotape	____	____	____	2.62*	-3.71*	0.00
Case 122	Control	-5.05*	-1.44	-1.67	-6.00*	-0.88	4.00*
Case 123	Videotape	-11.83*	3.60*	-7.00*	2.79*	1.29	0.00

Note. CBCL = Child Behavior Checklist, SSRS - S.S. = Social Skills Rating System, Social Skills Subscale, SSRS - Prob. Beh. = Social Skills Rating System, Problem Behavior Subscale, TRF = Teacher Report Form.

[a] Scores greater than 1.96 indicate behavior improvement.

[b] Scores less than -1.96 indicate improvement in social skills.

[c] Scores greater than 1.96 indicate behavior improvement. .

[d] Scores greater than 1.96 indicate behavior improvement.

* Indicates RC scores at $\pm$ 1.96, ($p > 0.5$) are significant.

Table 10

Summary of the Reliability Change Index for Pre-Post Measures by Group

	Manual					Videotape				
Reported Measures	N	M	SD	>1.96	<-1.96	N	M	SD	>1.96	<-1.96	N
Parent Measures											
CBCL[a]	12	4.52	4.50	75.0%	8.3%	31	1.33	5.57	41.9%	25.8%	-8
SSRS-Social Skills[b]	14	-1.64	1.70	0.0%	28.6%	34	-0.39	1.33	5.9%	11.8%	11
SSRS-Problem Behaviors[c]	14	3.60	3.92	57.1%	7.1%	34	2.15	5.17	44.1%	17.6%	11
Teacher Measures											
TRF[d]	19	0.99	5.89	31.6%	31.6%	35	0.83	3.88	31.4%	17.1%	14
SSRS-Social Skills	19	-0.81	1.75	5.3%	36.8%	39	-0.70	1.50	2.6%	20.5%	16
SSRS-Problem Behaviors	19	2.09	3.90	47.4%	5.3%	39	1.24	3.82	38.5%	15.4%	16

Note. CBCL = Child Behavior Checklist, TRF = Teacher Report Form, SSRS = Social Skills Rating System.

[a] Scores greater than 1.96 indicate behavior improvement.

[b] Scores less than -1.96 indicate improvement in social skills.

[c] Scores greater than 1.96 indicate behavior improvement. .

[d] Scores greater than 1.96 indicate behavior improvement.

As indicated in Table 10, the Reliability Change Index for scores on the Child Behavior Checklist shows parent pre-post measures demonstrating overall behavioral improvement in 75% of the cases in the manual group versus 37.5% improvement in the control group. Slight differences were noted between the videotape treatment group and the control group on the CBCL, with 41.9% improvement compared to 37.5% improvement, respectively. It should be noted, however, that 62.5% of the control groups behaviors deteriorated, whereas only 8.3% of the cases in the manual group and 25.8% in the videotape group appeared to worsen. Parents also rated improvement in social skills from pre to post treatment in the manual and videotape groups, but did not rate any case as improving in social skills in the control group.

In contrast to the parent report measures, teacher's report measures indicated only slight differences between groups on the overall behavior scales, with the manual group reporting the greatest improvement (i.e., SSRS-Problem Behaviors; 47.4% improvement). Behaviors also appeared to have deteriorated within the control group more frequently than in either treatment group, 42.9% of behaviors became worse in the control group versus 31.6% in the manual group and 17.1% in the videotape group. The teachers did rate overall improvement in social skill development after both treatments in comparison to the control group; 36.8% improvement in the manual group, 20.5% improvement in the videotape group, in comparison to 12.5% improvement in the control group.

Behavioral observation data and parent/teacher report of goal attainment also were used to determine treatment effectiveness. A comparison of the baseline and treatment phases of the direct behavioral observation data was conducted by using effect

sizes of the target behaviors (i.e., mean of baseline phase minus mean of the treatment phase divided by the variance of the baseline). Again, pooled variances were used for cases with no variance in the baseline data. Final GAS scores were obtained for each individual case by calculating the mean of the last 2 or 3 scores (GAS scores above 3 indicate a perceived positive behavioral change). Effect sizes and GAS by both parents and teachers for each individual case are presented in Table 11. Table 12 and 13 provide summaries of the effect size and GAS scores by treatment group. Effect sizes were calculated for 61 cases and ranged from -3.46 to 1.79 for the manual treatment group and -2.28 to 1.75 for the videotape treatment group, yielding mean effect sizes of -.08 and .05 for each group, respectively (see Table 12). Based on the binomial sign-test model, a 95% 1-tailed confidence interval for the median effect size is > -1.32. These results indicate that statistically, most of the case outcomes were positive for both groups. However, the actual improvement in behavioral outcomes when looking at the overall group mean scores for various behaviors (see Table 12), that is, behaviors actually improving from pretreatment to posttreatment was low. One area of exception appears to be the catch-all category of "other" behaviors, which appeared to improve moderately overall within the manual-based treatment group. The "other" category includes such target behaviors as participating, being on-task, and joining a group.

Parental reports of goal attainment were overall positive; 75% of the parents in the manual group and 95.5% in the videotape group reported goal attainment. Teachers reported goal attainment in 60% of their manual group cases and 73.1%

Table 11

Effect Sizes of Target Behaviors and Parent Teacher Goal Attainment Scores by Case

Target Behaviors	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 4	Manual			
Aggression		1.14	____	____
Case 7	Manual			
Disruptive Behavior		0.51	____	____
Case 9	Manual			
Fighting		0.11	____	____
Case 18	Manual			
Aggression		0.08	____	____
Case 19	Manual			
Aggression		0.83	____	____
Case 20	Manual			
Aggression		-0.82	____	____
Case 21	Manual			
Whining			4.00	____
Case 22	Manual			
Noncompliance		-0.35		
Aggression		-2.83		
Compliance			3.00	3.00
Case 24	Manual			
Compliance		0.52	5.00	2.70
Self-Control		0.75		
Case 25	Manual			
Controls Temper		-0.26		
Cooperation		0.36		
Tantrums			3.00	1.30
Case 26	Manual			
Compliance		-0.14	3.80	
Aggression		-0.87		____
Case 27	Manual			
Noncompliance		-0.75		
Angry Behavior		-0.94		
Compliance			3.70	3.30

Table 11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 29	Manual			
Aggression		-0.48		
Appr. Verbalizations		1.48	____	5.00
Case 31	Manual			
Aggression		-3.46	____	
				____
Case 32	Manual			
Aggression		0.80	4.30	5.00
Case 33	Manual			
Compliance		-0.93		
Joins Group		-0.94		
Self-Control			3.50	3.70
Case 34	Manual			
Participating		0.00	____	2.30
Withdrawing		0.64		
Case 35	Manual			
Compliance		-0.5	5.00	
Self-Control		0.72		
Pays Attention				4.70
Case 37	Manual			
Teasing		____	____	4.00
Case 44	Manual			
Self-Control		-1.19		3.00
Compliance		-0.42	3.00	

Table 11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 54	Manual			
Aggression		0.41	4.30	
Initiates		0.50		
Interactions				3.70
Case 57	Videotape			
Sharing		-0.33		
Noncompliance			4.50	
Off-Task				4.70
Case 58	Videotape			
Aggression		0.00		3.70
Compliance			4.80	
Case 59	Videotape			
Noncompliance		0.33	4.00	4.00
Aggression		0.33		
Case 61	Videotape			
Not Attending				4.30
Noncompliance		____	4.00	
Case 62	Videotape			
Noncompliance		1.18		
Aggression		-0.71	____	____
Case 63	Videotape			
Aggression		0.29	1.00	3.70
Case 64	Videotape			
Noncompliance		1.37	2.00	1.80
Case 66	Videotape			
Aggression		0.35	4.80	2.00
Noncompliance		0.35		
Case 67	Videotape			
Clinging			5.00	
Verbal Aggression		____		4.30
Case 69	Videotape			
Negative Verbalization		0.71	4.30	
Aggression				3.50
Noncompliance				

Table 11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 72	Videotape			
Noncompliance		1.75	4.00	4.00
Case 73	Videotape			
Physical Aggression		-0.61		
Verbal Aggression		0.77		
Aggression			5.00	3.70
Case 74	Videotape			
Noncompliance		-0.65	4.90	____
Case 76	Videotape			
Sulking		0.71		
Leaves Group		0.71		
Compliance			4.00	3.00
Case 77	Videotape			
Physical Aggression		2.21		
Verbal Aggression		.94		
Aggression			____	3.00
Case 78	Videotape			
Aggression		1.15	4.70	____
Cooperation		.28		
Case 81	Videotape			
Tantrum		-0.82	3.30	____
Compliance		-0.09		
Case 82	Videotape			
Attention Seeking		1.85		
Initiating		-2.60		3.00
Independent Behavior			3.70	
Case 83	Videotape			
Aggression		0.54	3.50	
Immature Behavior		-0.35		
Appropriate Behavior				4.00

Table 11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 85	Videotape			
Compliance		1.41		
Tantrums		-1.77	3.00	____
Case 87	Videotape			
Compliance		0.15		
Tantrums			4.00	____
Case 89	Videotape			
Noncompliance		0.00		
Compliance		1.73	____	3.00
Case 90	Videotape			
Noncompliance		-0.94		
Initiates		1.18		
Compliance			4.33	2.30
Case 93	Videotape			
Noncompliance		0.24	4.00	____
Case 94	Videotape			
Noncompliance		0.71		
Compliance		0.57	5.00	2.00
Case 95	Videotape			
Compliance		-1.06		
Aggression		-0.35		
Talking Back			2.70	
Sharing				4.00
Case 96	Videotape			
Compliance		-1.40	4.00	____
Case 97	Videotape			
Tantrums		0.30	4.70	4.70
Taking Turns		0.75		
Case 98	Videotape			
Withdrawal		1.26		
Acceptance		-0.94	3.00	5.00
Case 99	Videotape			
Uncooperative		1.05		
Cooperative		-2.20	3.30	
Tantrums				3.70

Table 11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 100	Videotape			
Tantrums		0.00	4.00	3.30
Case 102	Videotape			
Compliance		-1.65	4.00	____
Aggression		-0.59		
Case 107	Videotape			
Cooperation		-1.24		
Loss of Self-Control		-3.32		
Self-Control			____	4.00
Case 108	Videotape			
Aggression		0.63		
Noncompliance		1.01		
Tantrums			4.00	4.00
Case 109	Videotape			
Inappropriate Verbal		-0.67		
Appropriate Verbal		1.06	3.20	3.20
Case 111	Videotape			
Noncompliance		-1.22		
Compliance		0.71	____	2.60
Case 112	Videotape			
Crying		-3.29	4.70	4.00
Case 113	Videotape			
Aggression		0.58		
No Self-Harm			____	2.60
Case 116	Videotape			
Aggression		-0.30		
Appropriate Verbal		0.30	4.00	4.30
Case 118	Videotape			
Stealing		0.64		
Noncompliance		-1.50	____	____
Case 119	Videotape			
Hitting		0.18		
Compliance		-0.12		
Aggression			4.00	4.30

Table11 (continued)

Target Behavior	Type of Treatment	Effect Size[a]	Parent GAS[b]	Teacher GAS[c]
Case 120	Videotape			
Appropriate Verbal		3.53	____	3.00
On-Task		-0.34		
Case 123	Videotape			
Compliance		-1.32	5.00	3.30

Note. GAS = Goal Attainment Scaling.

[a] Positive effect size indicates an improvement in behavior, negative effect size indicates that

behavior has deteriorated; based on the binomial sign-test model, a 95% 1-tailed confidence

interval for the median effect size > -1.32

[b and c] GAS scores below 3.00 indicate behavior deteriorated, scores at 3.00 indicate no

behavior change, and above 3.00 indicate an improvement in behavior

Table 12

Summary of Effect Size of Grouped Behaviors from the Direct Observations

	Manual			Videotape		
Behaviors	N	M	Range	N	M	Range
Aggression	14	-.41	-3.46 to 1.14	21	.15	-1.77 to 2.21
Compliance	8	-.28	-.93 to .52	24	.08	-1.65 to 1.75
Other	10	.55	-1.19 to 3.00	23	-.05	-3.32 to 3.53
Total	32	-.08	-3.46 to 1.79	68	.05	-3.32 to 3.53

Table 13

Summary of Parent and Teacher Goal Attainment Scores

	Manual				Videotape				
	N	M	SD	>3.0	<3.0	N	M	SD	>3.0	<3.0
Parent	8	3.94	.79	75%	0%	22	4.27	.63	95.5%	4.5%
Teacher	10	3.50	1.22	60%	30%	26	3.60	.79	73.1%	15.4%

of their videotape group cases. It should be noted that 30% of the manual group cases were rated by the teachers as not reaching their goal, whereas 15.4% of the teachers indicated this in the videotape treatment group. These results were further analyzed using a MANOVA, which indicated no significant group effect for the effect size data or reported GAS for teachers or parents, $F(1,22) = .84$, $p < .52$.

Treatment Acceptability and Social Validity (Question 4 & 5).

On the treatment effectiveness questionnaires (TEQ), both parents and teachers for both the manual and videotape treatment groups reported overall high scores on all three subscales (i.e., treatment acceptability, effectiveness, and time; see Table 14). A MANOVA revealed no significant group effect for the parents' perception of treatment effectiveness, $F(1,24) = .86$, $p < .48$. Similarly, on the teachers' report of treatment effectiveness, a MANOVA indicated no significant group differences, $F(1,33) = .55$, $p < .65$.

Overall high scores also were obtained on the parent and teacher Consultation Satisfaction Questionnaires, indicating that both consultees reported the consultation treatments (both manual and videotape treatment programs) to be helpful programs (see Table 15). Using the overall score for this measure, an ANOVA indicated no significant effect between the treatment groups on the parent questionnaire, $F(1,20) = .39$, $p < .53$, nor did the same test indicate a group effect for the teacher questionnaire, $F(1,43) = .53$, $p < .47$.

Table 14

Parent and Teacher Treatment Evaluation Questionnaire Scores

Treatment Evaluation Subscales	Manual			Videotape		
	N	M	SD	N	M	SD
Acceptability Score[a]						
Parent	13	58	6	12	55	5
Teacher	15	74	9	20	71	8
Effectiveness Score[b]						
Parent	13	35	8	12	36	7
Teacher	15	34	9	20	33	7
Amount of Time for Improvement[c]						
Parent	13	9	2	12	9	1
Teacher	15	9	2	20	8	2

Note. [a] Parent scores range from 11 to 66, greater scores indicate better acceptability.

Teacher scores range from 14 to 82, greater scores indicate better acceptability.

[b] Scores range from 8 to 48, greater scores indicate stronger effectiveness.

[c] Scores range from 2 to 12, greater scores indicate faster behavior improvement.

Table 15

Parent and Teacher Consultation Services Questionnaire Scores

		Manual			Videotape	
	N	M	SD	N	M	SD
Parent	9	248.11	28.43	13	241.54	20.93
Teacher	17	248.47	22.41	28	243.57	21.39

Note. Parent scores range from 23 - 294 & teacher scores range from 22 - 287, greater scores indicate greater level of satisfaction

Table 16

Responding to Children's Behaviors Item Scores

			Parent			Teacher	
Subscale Items	# of Times	N	Pretest	Posttest	N	Pretest	Posttest
Raising Voice	Never	17	0	0	20	2	2
	Rarely		1	6		8	14
	Sometimes		5	9		8	4
	Frequently		11	2		2	0
Correct Problem	Never	17	0	1	20	3	3
	Rarely		2	3		2	3
	Sometimes		8	8		9	8
	Frequently		7	5		6	6
Threaten Punishment	Never	17	0	1	20	7	9
	Rarely		2	4		10	5
	Sometimes		6	8		3	4
	Frequently		9	4		0	2
Restrict Privileges	Never	17	2	2	20	2	2
	Rarely		3	5		6	6
	Sometimes		9	9		11	9
	Frequently		3	1		1	3
Ignore	Never	17	4	3	20	1	0
	Rarely		4	5		1	6
	Sometimes		8	6		14	8
	Frequently		1	3		4	6
Follow thru with Consequences	Never	17	0	0	20	0	1
	Rarely		3	4		1	1
	Sometimes		9	8		2	1
	Frequently		5	5		17	17
Spank or Slap	Never	17	2	7	20	19	20
	Rarely		9	5		1	0
	Sometimes		6	5		0	0
	Frequently		0	0		0	0
Bad Mark on Chart	Never	16	12	11	20	18	18
	Rarely	or	0	2		0	0
	Sometimes	17	2	3		2	2
	Frequently		2	1		0	0
Time Out	Never	17	2	1	20	1	2
	Rarely		0	2		7	5
	Sometimes		5	8		7	8
	Frequently		10	6		5	5

Table 16 (Continued)

			Parent			Teacher	
Subscale Items	# of Times	N	Pretest	Posttest	N	Pretest	Posttest
Tell to Stop Misbehaving	Never	17	1	0	20	1	2
	Rarely		0	0		3	6
	Sometimes		4	9		13	10
	Frequently		12	8		3	2
Get Attention/Redirect	Never	17	1	1	19	0	1
	Rarely		1	4	or	2	1
	Sometimes		13	10	20	10	8
	Frequently		2	2		8	9
Verbally Praise	Never	17	0	0	20	0	0
	Rarely		1	0		0	0
	Sometimes		5	4		4	3
	Frequently		11	13		16	17
Provide Unexpected Reward	Never	17	0	1	20	3	1
	Rarely		5	2		1	3
	Sometimes		8	11		14	12
	Frequently		4	3		2	4
Give Hug or Kiss	Never	17	0	0	20	1	0
	Rarely		1	1		1	1
	Sometimes		2	3		12	8
	Frequently		14	13		6	11
Put Good Mark on Chart	Never	16	11	8	20	13	14
	Rarely	or	1	4		2	0
	Sometimes	17	1	2		3	3
	Frequently		4	2		2	3
Provide Expected Reward	Never	17	1	2	20	4	6
	Rarely		2	3		4	3
	Sometimes		10	8		7	7
	Frequently		4	4		5	4
Give Special Privilege	Never	17	0	2	20	3	1
	Rarely		2	3		3	5
	Sometimes		12	10		9	11
	Frequently		3	2		5	3

Frequency data are presented in Table 16 regarding parent and teacher responses to children's behaviors before and after the videotape treatment. Overall, it appears that parents and teachers reported little change in the frequency of their responses to children's behaviors. A t-test for paired samples was used to analyze the overall scores for responding to children's positive behaviors (obtained from mean scores of the last six items on the RCB.) There were no significant differences found between the parent responses on the pre-post measures, $t(15) = -.73$, $p<.48$, nor were significant differences found between the pre-post teacher measures, $t(19) = .68$, $p<.51$. Although there were no significant differences found between the pre-post RCB measures, it is interesting to note some of the changes that may have more clinical significance. For example, while 11 parents responded that they frequently raise their voice at their child during the baseline stage, only 2 reported frequent raising of their voices after viewing the videotapes. Many teachers also reported a decrease in raising their voices to control student behaviors. Parents reported that they threaten punishment less often and after viewing the videotapes and participating in the program. Also, teachers reported an increase in the use of physical praise (i.e., hugs, patting back) toward children's appropriate behaviors.

Treatment Integrity (Question 6)

Parent and teacher integrity checklists were completed differently during the two phases of treatment, because of the different intervention formats. During the first two years of the project, treatment integrity was reported in percentages; eleven parents and

Table 17

Parent and Teacher Treatment Integrity Scores (Videotape Group Only)

	N	M	SD
Watched Videotape[a]			
Parent	24	26.58	.65
Teacher	16	25.31	3.00
Treatment Integrity Total[b] Score			
Parent	19	102.95	13.49
Teacher	4	108.00	13.49

Note. [a] Scores range from 9 - 27, greater scores indicate higher % of tapes viewed.

[b] Scores range from 40 - 120, greater scores indicate higher % integrity.

nine teachers reported 69% compliance with the treatment program and activities, which is a moderate level of compliance.

During the last three years of the project, the parents and teachers who completed the integrity checklists reported overall high treatment integrity scores (see Table 17). They reported watching most of the videotapes and participating in most of the treatment suggestions. It was hypothesized that high treatment integrity scores would correlate strongly with effect size scores from the direct observations of the target behaviors. Using a Pearson correlation coefficient, the correlation between the parent integrity score and the effect size for the first target behavior and second target behaviors was low, .15 and .28, respectively. Only two cases were represented for the examination between teacher integrity scores and the effect sizes for the first target behavior. On the case where there was reportedly high treatment integrity, the effect size demonstrated a positive behavior change, whereas on the case with low teacher treatment integrity, the effect size suggested a deterioration in the target behavior through treatment.

A deviant case study analysis was conducted to describe both quantitative and qualitative information regarding two different cases; one that appeared successful and one that appeared unsuccessful, based upon convergent evidence scaling. Convergent evidence scaling included examining parent and teacher outcome measures (i.e., reliability change index score and goal attainment scales) and the direct observation data (i.e., effect sizes) from individual cases and comparing results to indicate overall positive, negative or mixed results. The cases were chosen from all cases receiving some form of intervention (manual or videotape). Based on convergent evidence scaling, case

107 appears to be an unsuccessful case regarding observed behavior change and teacher report of behavior change, whereas case 72 appears to be a successful case when looking at both observed behavior change and parent/teacher report of behavior change. Both cases appear to be similar in that they were both involved in the videotape intervention program and the students were of the same gender. However, there was documented information regarding participation in the program by the parent of case 72, and a lack of participation by the parent in case 107.

Case number 107, which appeared to be unsuccessful, was initially referred due to behavior difficulties within the home environment, specifically uncooperative behaviors and lack of self-control (e.g., throwing objects and hurting others). After the pre-tests were rated by the teacher and parent, Case 107 began to have more behavioral difficulty within the school environment, also including a "loss of self-control." The parent agreed to let the teacher participate in the program and develop an intervention plan, but did not watch the videotape series or participate herself. The teacher's plan came out of the knowledge learned and demonstrated in the videotapes and included a behavior chart with stickers used as rewards. Case 107 exhibited more cooperative behavior than another comparison peer observed within the classroom, but his "loss of self-control" was seen at a greater rate than other comparison peers. As indicated in Table 11, the effect size for the target behaviors of cooperation and loss of self-control were negative, indicating a deterioration in both observed behaviors from pre to post treatment. The teacher reported that the goal of the intervention was moderately effective, based upon her perception and experiences. Case 107 also appeared to have

more behavioral problems at school toward the end of treatment versus the beginning of treatment. On both of the teacher's pre-post behavior checklist measures, the Teacher Report Form and the Social Skills Problem Behavior Checklists, indicated that the students overall behavior became significantly worse from pre to post treatment (see Table 9).

Case 72 was determined to be a successful case after treatment, that is, the student's behaviors were seen to have improved from pre to post treatment. The teacher and parent referred this student because of noncompliant behaviors that were occurring across settings. Both the parent and the teacher participated in the intervention program. The target behaviors chosen for the intervention were noncompliant behaviors. As indicated in Table 11, Case 72 demonstrated statistically and clinically significant improvements on the target behavior of "noncompliance" as determined through effect sizes of the classroom observations. Both the parent and teacher also reported improvement through goal attainment scaling (see Table 11). Finally, as indicated in Table 9, both the parent and teacher reported significant improvements in overall behaviors and the mother indicated a significant improvement in social skills, as determined through pre-post behavioral checklists.

Chapter VI

Discussion

This research involved an evaluation of the effectiveness of two conjoint behavioral consultation treatment methods in comparison to a control group; the first treatment approach involved a self-administered manual-based treatment and the second treatment approach used a self-administered videotape treatment format. Treatment effectiveness was evaluated through both group design and single-case design formats. Reports of treatment acceptability and social validity along with an evaluation of treatment integrity were also analyzed in the current study. The evidence and the resulting conclusions for each of the research hypotheses are discussed below.

The first three hypotheses investigated treatment effectiveness on various measures and between the two treatment groups and control group. Specifically, it was hypothesized that the parents and teachers would report greater improvement of students' behaviors on the posttests within the experimental groups (manual and videotape) compared to the control group and that this improvement would be statistically greater within the videotape group versus the manual group. It was also predicted that both treatment groups would demonstrate improvement in students' target behaviors by measuring both the effect sizes of the direct observations and the goal attainment scales completed by teachers and parents. Again, the videotape treatment group was predicted to have better outcomes on both measures compared to the manual treatment group. These predictions were based upon past research conducted by Webster-Stratton and her associates (see Webster-Stratton, 1992; Webster-Stratton & Hancock, 1998), who

reported strong success rates on similar measures in a study conducted with the same videotapes administered to parents of younger children. This research also extended the work of Webster-Stratton through use of a formal process of consultation that was relatively standardized (i.e., behavioral consultation outlined by Bergan & Kratochwill, 1990) and the focus of teacher training. Finally, the research involved an extension of the Rotto and Kratochwill (1992) study in that the manual-based treatment was implemented in a self-administered format rather than with formal direct parent training.

In the current study, parent and teacher report measures were also used to evaluate treatment outcomes through both a group design format and single-case methodologies. In the group design method, no significant difference was found between groups on the parent and teacher self-report measures of students' behaviors and social skills. Slight differences between the treatment and control group were found on the parent self-report measures, although these differences were not found to be statistically significant. Although, as noted in the results section, the statistical power to obtain significance was low due to small group sizes and large variance (see Kazdin, 1998).

Another method developed for single-case research design methodology was used to further analyze the parents and teachers pre-posttests. A reliability change index (RCI) was used to determine the effectiveness of the interventions through parent and teacher reports; that is, pretest mean minus the posttest mean divided by the standard error of measurement for the given outcome measure. The RCI indicated that on the problem behavior scales, the manual group improved the most compared to the videotape and control groups on both the parent and teacher pre-post measure, in contrast, the

videotape group demonstrated only slight improvement from the control group on the parent problem behavior measures.

It is interesting to note the deterioration of behaviors in each group, that is, which groups the parents and teachers rated the students' behaviors as significantly worse from pre-post test. On both the parent and teacher measures, more students' behaviors were reported as deteriorating in the control group from pre- to post test versus the treatment groups. On the parent measures, the manual group was rated as having the least amount of behavior problems worsening whereas in the teachers' responses, the videotape treatment group reported the least amount of behaviors deteriorating from pretests to posttests.

On the parent and teacher pre-posttests there appears to be mixed results; that is, the MANCOVA's revealing no significant results between groups and the RCI data indicating differences between the groups. As stated above, the group analysis was not sensitive enough to detect differences between the groups, because of small group size and large variance. However, when analyzing the data through single-case design methods, smaller differences between the pre-posttest data were apparent. Both treatment groups demonstrated improved behaviors within more cases when compared to the control group; the manual treatment group reporting the greatest number of behavioral improvements. It is also important to note that the RCI data indicated the control group had more cases that experienced a deterioration in behaviors compared to the two treatment groups, with the manual group demonstrating the least amount of cases with worsening behaviors. Finally, the RCI data indicates an improvement in social skill

usage in both treatment groups compared to the control group. Overall, the evidence indicated by the RCI data shows that the treatment groups were more effective than the control group on broad-based pre-post measures, with the manual group demonstrating the most success in behavior improvement.

In comparison to the previous parent training research (see Webster-Stratton, 1992; Webster-Stratton & Hancock, 1998), results supporting treatment effectiveness were more modest. The Webster-Stratton research found significant group effects on the mother and father self-report measures between the videotape treatment group and control group. Again, it should be emphasized that the group size in the current study was significantly smaller than in the Webster-Stratton research, thus treatment effects were difficult to detect statistically. Still, the single-case data appears to support positive outcomes for the treatment groups, compared to the control group, which is similar to the Webster-Stratton conclusions and some other parent outcome research (see Miller, 1998).

Treatment effectiveness was further investigated by using behavioral observation data and goal attainment scores, to compare the effectiveness of the two treatment groups. Direct observational data were analyzed using the effect sizes of the target behaviors. Although statistical results were positive, overall behavior change for both treatment groups was low. In contrast, goal attainment scores demonstrated more positive results, 95.5% of parents and 75% of parents reported significant improvement in target behaviors in the videotape group and manual group, respectively. Teachers indicated goal attainment in 60% of cases in the manual group and 73.1% of cases in the videotape group. There were no statistically significant differences found between the

manual-based and videotape-based treatment groups on either the effect size data nor the GAS.

The results obtained from the GAS and effect size data, both of which are measurements of the specific target behaviors in each case, appear to be conflicting. Parents and teachers reported 60 to 95% improvement in target behaviors through GAS data within both treatment groups, however, the effect size data indicated little improvement. Although the parents and teachers could be biased observers (i.e., they were participants and not blind to the conditions of the study), they also had observed the students' behaviors over a greater amount of time. On the other hand, the effect size data were calculated from the direct observation data of the target behaviors, where outside observers would collect data within 30 minute segments. This difference in the amount of time observing the students' behaviors could be one reason for the conflicting results. Also, some of the behaviors that were to be assessed (e.g., aggression, tantrums) were not possible to sample during the observation sessions. Finally, direct observation data were not collected in the home settings.

Although the Webster-Stratton research did not include goal attainment scaling, it did include a home direct observation component. In the Webster-Stratton work, home observations were conducted for two 30-minute intervals during each assessment period. Results indicated a significant difference between the children's noncompliant behavior between control group and the treatment group when interacting with the fathers, but no significant difference when interacting with the mothers. In the current study, more observations were conducted during each assessment period but were completed only

within the classroom environment. Because of these factors, it is impossible to compare the two studies on this variable.

Treatment acceptability and social validity were other areas examined in this study. It was predicted that the parents and teachers would report that both programs were effective, acceptable and satisfactory overall, and that the videotape program would receive better scores compared to the manual-based program. Both parents and teachers reported high scores within both treatment groups on the treatment effectiveness questionnaires and the consultation satisfaction questionnaires. Thus, both the teachers and parents reported overall high levels of program effectiveness, acceptability and satisfaction. On both parent and teacher measures, slightly higher scores were obtained within the manual-based treatment group versus the videotape group, however, there was no statistically significant difference found. The Webster-Stratton and associates research has not included any formal assessment of treatment acceptability.

Responding to children's behavior checklist was used specifically to measure parent and teacher responses to the students' behaviors from a pre-post treatment format through a self-report measure adapted from the Webster-Stratton research (1992). It was predicted that both parents and teachers would demonstrate positive behavior changes in how they responded to their children's behaviors. Although there were no statistically significant differences noted between pre and posttests, parents and teachers did respond differently to specific questions. Some behaviors of clinical significance include an increase in teacher's use of physical praise and a decrease in parents using threats or raising their voices to control their child's behaviors. Similar results were obtained in

the Webster-Stratton research; mothers reported less use of spanking, time-out, targeted negative behaviors, and increased observations of prosocial behavior. However, the Webster-Stratton research compared the mother's self-report of behaviors between the treatment and control group, whereas in the current study, comparisons were made between pretest and posttest behaviors.

Finally, it was hypothesized that the level of treatment integrity would have a positive influence on behavior change, measured through effect sizes of the direct observational data. Of the teachers and parents that completed the checklists, treatment integrity was moderate to high. Of course, the participants that completed the checklists were probably the ones who complied with most of the treatment conditions, thus potentially biasing the results. The correlation for parent treatment integrity data compared to the direct observation effect sizes was small. Checklists regarding treatment integrity of the participants were not used in the Webster-Stratton and associates research.

Strengths and Contributions of the Study

This research project involved an investigation on the effectiveness of self-administered parent and teacher training materials by providing a comparison study to manual-based research of Webster-Stratton and Rotto and Kratochwill (1994). By broadening the research questions, information for consultation research and practice was provided, addressing some of the recent pleas for more consultation outcome research in school psychology (Noell & Witt, 1996).

As mentioned earlier in the introduction, research in behavioral consultation has primarily been conducted with teachers within the school setting (Sheridan, et al. 1988), whereas research in the area of adult training has focused mainly on parent training formats (Elliott & Busse, 1993). This research project enhanced the existing research base by utilizing a conjoint behavioral consultation model, which involved both the teacher and parents in implementing similar treatments across settings (i.e., home, school and community). This component differs from both the Rotto and Kratochwill (1994), and Webster-Stratton research in that it includes a teacher training focus. Both of the earlier studies centered primarily on parent training techniques. At the conceptual level, it was expected that the conjoint treatment focus would have added treatment strength to the intervention protocol. Unfortunately, involving both parents and teachers in the treatment did not seem to have a strong impact on child behavior.

Second, the current study included children with both internalizing (i.e., withdrawn, depressed) and externalizing behavior problems (i.e., aggression, noncompliance). The research conducted by Rotto and Kratochwill (1994) was directed specifically at managing noncompliant behavior. Similarly, the effectiveness of the videotape series (developed by Webster-Stratton) was studied on conduct disordered children or children who were exhibiting externalizing behavior difficulties. Thus, the current study enhances the research base by including participants who are exhibiting internalizing behavioral difficulties, although the research did not show an impact of the treatment (possibly due to low number of identified cases).

Overall, the current study also extended the research base on the effectiveness of conjoint behavioral consultation (see Noell & Witt, 1996). Sheridan and Kratochwill (1992) outlined the specific areas in need of research in this particular area of consultation and important aspects of investigation to include in consultation projects. This study contributed to many research areas outlined, including; (a) providing experimental control, (b) using direct observations, (c) assessing broad-based behaviors, (d) examining teacher/parent perceptions of treatment outcomes, (e) analyzing teacher/parent acceptance of treatment, (f) monitoring treatment integrity for the consultant and consultees. Although the research extends the knowledge base in the area of consultation, it does not provide a strong argument for the use of the two treatments featured in the consultation process.

Limitations of the Study

Several shortcomings and limitations were present in the current research. Although the participants were randomly assigned to a treatment or control group, the treatment groups were not randomly assigned, due to the timing of the comparisons. That is, the manual-based treatment group consisted of participants from the first two years of the project, while the videotape-based treatment group were participants from the last three years. The decision to change treatments after the second year of the project was due to the knowledge of a successful study using similar training techniques on a comparable population, that is, the Webster-Stratton research involving a self-administered format with "minimal therapist contact." Because the two treatment formats were used during different years, it is difficult to compare their results. Many

unknown variables could certainly influence the overall outcomes of the treatments within any given year. Thus, in future research endeavors, it would be beneficial to randomly assign subjects to all treatment conditions.

Another limitation of the current research was the large amount of missing data. Many checklists were not completed or returned from the participants in the current study and the return rate of the follow-up data was very poor.

Future Research

The results of the present study generates a number of questions for future research. In comparison to the Webster-Stratton and associates research, this study reported modest results at best. It would be interesting to examine the various conditions for successful behavior change in consultation research, such as level of parent involvement, level of education, SES, etc. This is an area already investigated by Webster-Stratton (1992); that is, determining which variables were related to treatment outcome. Webster-Stratton (1992) has already investigated some of these variables, along with other predictors such as level of parent depression, number of negative life experiences and marital status.

Further investigation should be conducted self-administered training programs for students who exhibit internalizing behavioral problems. Although this was an intended area of investigation for this study, the lack of identified participants made it difficult to compare results. Perhaps a single-case research design format may be more conducive for this type of research, because of the under-identification of these behavioral issues in our schools.

Continued linking of school and home based interventions for children is also warranted (Sheridan & Kratochwill, 1992). Investigating similar formats that can be used easily by parents and teachers and that are "consumer friendly" and effective for behavioral improvement are other areas of important research.

References

Achenbach, T.M. (1991). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T.M. (1991). Manual for the Teacher's Report Form and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Anesko, K.M., & O'Leary, S.G. (1982). The effectiveness of a brief parent training for the management of children's homework problems. Child and Family Behavior Therapy, 4(2/3), 113-127.

Bauman, K.E., Reiss, M.L., Rogers, R.W., & Bailey, J.S. (1983). Dining out with children: Effectiveness of a parent advice package on pre-meal inappropriate behavior. Journal of Applied Behavior Analysis, 16, 55-68.

Becher, R.M. (1986). Parent involvement: A review of research and principles of successful practice. In L.G. Katz (Ed.). Current topics in early childhood education (Vol. VI) (pp. 85-122). Norwood, N.J.: Ablex Publishing Corporation.

Bergan, J.R., & Kratochwill, T.R. (1990). Behavioral consultation in applied settings. New York: Plenum.

Bernal, M.E., & North, J.A. (1978). A survey of parent training manuals. Journal of Applied Behavior Analysis, 11, 533-544.

Brock, G., & Coufal, J.D. (1985). Parent education as skills training. In L. L'Abate & M.A. Milan (Eds.), Handbook of Social Skills Training and Research (pp. 263-283). New York: John Wiley & Sons.

Clark, H.B., Greene, B.F., Macrae, J.W., McNees, M.P., Davis, J.L., & Risley, T.R. (1977). A parent advice package for family shopping trips: Development and evaluation. Journal of Applied Behavior Analysis, 10, 605-624.

Cobb, D.E., & Medway, F.J. (1978). Determinants of effectiveness in parent consultation. Journal of Community Psychology, 6, 229-240.

Conners, C.K. (1973). Rating Scales for use in drug studies with children. Psychopharmacology Bulletin, (Special Issue: Pharmacotherapy with Children), 24-84.

Crosbie, J., & Sharpley, C.F. (1991). A Statistical Program for Analyzing Data from Interrupted Time-Series. Victoria: Australia.

Dinkmeyer, D., & McKay, G.D. (1982). The parents handbook: Systematic training for effective parenting. Circle Pines, MN: American Guidance Service.

Dougherty, E.H., & Dougherty, A. (1977). The daily report card: A simplified and flexible package for classroom behavior management. Psychology in the Schools, 14, 191-195.

Elliott, S.N., Barnard, J., & Gresham, F.M. (1989). Preschooler's social behavior: Teachers' and parents' assessments. Journal of Psychoeducational Assessment, 7, 223-234.

Elliott, S.N., & Busse, R.T. (1993). Effective Treatments with Behavioral Consultation. In J.E. Zins, T.R. Kratochwill, & S.N. Elliott (Eds.) Handbook of Consultation Services for Children (pp. 15-45). San Francisco, CA: Jossey-Bass, Inc.

Elliott, S.N., Gresham, F.M., Freeman, T., & McCloskey, G. (1988). Teacher observations and behavior ratings of children's social skills. Journal of Psychoeducational Assessment, 61, 25-135.

Endo, G.T., Sloane, H.N., Hawkes, T.W., McLoughlin, C., & Jenson, W.R. (1991). Reducing child tantrums through self-instructional parent training materials. School Psychology International, 12, 95-109.

Flanagan, S., Adams, H.E., & Forehand, R. (1979). A comparison of four instructional techniques for teaching parents to use time-out. Behavior Therapy, 10, 94-102.

Forehand, R.L., & McMahon, R.J. (1981). Helping the noncompliant child: A clinician's guide to parent training. New York: The Guilford Press.

Giebenhain, J.E., & O'Dell, S.L. (1984). Evaluation of a parent-training manual for reducing children's fear of the dark. Journal of Applied Behavioral Analysis, 17, 121-125.

Gordon, T. (1970). P.E.T.: Parent Effectiveness Training. New York: Peter H. Wyden, Inc.

Gresham, F.M., & Elliott, S.N. (1990). The Social Skills Rating System. Circle Pines, MN: AGS.

Harris, F.N., & Jenson, W.R. (1985). Comparisons of multiple-baseline across persons designs and AB designs with replication: Issues and Confusions. Behavioral Assessment, 7, 121-127.

Henning-Stout, M. (1993). Theoretical and Empirical Bases of Consultation. In J.E. Zins, T.R. Kratochwill, & S.N. Elliott (Eds.) Handbook of Consultation Services for Children (pp. 15-45). San Francisco, CA: Jossey-Bass, Inc.

Henry, S.A. (1981). Current dimensions of parent training. School Psychology Review,10, 4-14.

Johnson, C.A., & Katz, R.C. (1973). Using parents as change agents for their children: A review. Journal of Child Psychology and Psychiatry, 14, 181-200.

Kazdin, A.E. (1977). Assessing the clinical or applied importance of behavior change through social validation. Behavior Modification, 1, 427-452.

Kazdin, A.E. (1980). Acceptability of alternative treatments for deviant behavior. Journal of Applied Behavior Analysis, 13, 259-273.

Kazdin, A.E. (1981). Acceptability of child treatment techniques: The influence of treatment efficacy and adverse side effects. Behavior Therapy, 12, 493-506.

Kazdin, A.E. (1982). Single-case research designs: Methods for clinical and applied settings. New York: Oxford University Press.

Kazdin, A.E., French, N.H., & Sherick, R.B. (1981). Acceptability of alternative treatments for children: Evaluations by inpatient children, parents, and staff. Journal of Consulting and Clinical Psychology, 49, 900-907.

Kelley, M., Heffer, R., Gresham, F., & Elliott, S.N. (1986). Development of a modified treatment evaluation inventory. Journal of Psychopathology and Behavior Assessment.

Kiresuk, T.J., Smith, A., & Cardillo, J.E. (1994). (Eds.) Goal Attainment Scaling: Applications, Theory, and Measurement. Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Koven, G.T., & LeBow, M.D. (1973). Teaching parents to remediate the academic problems of their children. The Journal of Experimental Education, 41, 64-73.

Kramer, J.J. (1990). Training parents as behavior change agents: Successes, failures, and suggestions for school psychologists. In T.B. Gutkin & C.R. Reynolds (Eds). The Handbook of School Psychology (pp. 683-702). New York: Wiley. Kratochwill, T.R. (1998).

Kratochwill, T.R., & Bergan, J.R. (1990). Behavioral Consultation in Applied Settings: An Individual Guide. New York: Plenum.

Kratochwill, T.R., Sheridan, S.M., & Van Someren, K.R. (1988). Research in behavioral consultation: Current status and future directions. In F. West (Ed.), School consultation: Interdisciplinary perspectives on theory, research, training, and practice (pp. 77-102). Austin, TX: University of Texas Press.

Loitz, P.A., & Kratochwill, T.R. (1994). The Effectiveness of a Parent Training Manual for Children's Homework Problems. Manuscript submitted for publication.

Marascuilo, L.A., & Busk, P.L. (1988). Combining Statistics for Multiple-Baseline AB and Replicated ABAB Designs Across Subjects. Behavioral Assessment, 10, 1-28.

Marascuilo, L.A., & Serlin. (1988). Statistical Methods for the Social and Behavioral Sciences. New York: W.H. Freeman and Company.

McLoughlin, C.S. (1982). Procedures and problems in behavioral training for parents. Perceptual and Motor Skills, 55, 827-838.

McMahon, R.J., & Forehand, R. (1978). Nonprescription behavior therapy: Effectiveness of a brochure in teaching mothers to correct their children's inappropriate mealtime behaviors. Behavior Therapy, 9, 814-820.

Medway, F.J. (1979). How effective is school consultation: A review of recent research. Journal of School Psychology, 17, 275-282.

Medway, F.J., & Updyke, J.F. (1985). Meta-analysis of consultation outcome studies. American Journal of Community Psychology, 13, 489-505.

Miller. (1998).

Nay, W.R. (1975). A systematic comparison of instructional techniques for parents. Behavior Therapy, 6, 14-21.

Noell, G.H., & Witt, J.C. (1996). A critical re-evaluation of five fundamental assumptions underlying behavioral consultation. School Psychology Quarterly, 11, 189-203.

O'Dell, S. (1974). Training parents in behavior modification: A review. Psychology Bulletin, 81, 418-433.

O'Dell S.L., Krug, W.W., Patterson, J.N., & Faustman, W.O. (1980). An assessment of methods for training parents in the use of time-out. Journal of Behavior Therapy and Experimental Psychiatry, 11, 21-25.

O'Dell, S.L., Mahoney, N.D., Horton, W.G., & Turner, P.E. (1979). Media-assisted parent training: Alternative models. Behavior Therapy, 10, 103-110.

O'Dell, S.L., O'Quin, J.A., Alford, B.A., O'Briant, A.L., Bradlyn, A.S., & Giebenhain, J.E. (1982). Predicting the acquisition of parenting skills via four training methods. Behavior Therapy, 13, 194-208.

Ollendick, T.H., & Cerny, J.A. (1981). Clinical Behavior Therapy With Children. New York: Plenum Press.

Olympia, D., Jenson, W.R., Clark, E., & Sheridan, S. (in press). Training parents to facilitate homework completion: A model for home-school collaboration. In S.L. Christenson and J.C. Conoley (Eds.) Home-School Collaboration: Building a Fundamental Educational Resource. Silver Spring, MD: National Association of School Psychologists.

Quay, H.C., & Peterson, D.R. (1983). Interim Manual for the Revised Behavior Problem Checklist. Coral Gables, FL: University of Miami.

Reisinger, J.J., Ora, J.P., & Frangia, G.W. (1976). Parents as change agents for their children: A review. Journal of Community Psychology, 4, 103-123.

Rotto, P.C. & Kratochwill, T.R. (1994). Behavioral Consultation with Parents: Using Competency-Based Training to Modify Child Noncompliance. School Psychology Review, 23, 669-693.

Rosen, G.M. (1993). Self-Help or hype?: Comments on psychology's failure to advance self-care, Professional Psychology: Research and Practice, 24, 340-345.

Rubin, K.H. & Stewart, S.L. (1996). Social withdrawal. In E.J. Mash & R.A. Barkley (Eds.) Child Psychopathology (pp. 277-307). New York, NY: The Guilford Press.

Scogin, F., Bynum, J., Stephens, G., & Calhoon, S. (1990). Efficacy of self-administered treatment programs: Meta-analytic review. Professional Psychology: Research and Practice, 21(1), 42-47.

Shapiro, E.S. (1987). Behavioral assessment in school psychology. Hillsdale, NJ: Lawrence Erlbaum Associates.

Sheridan, S.M., Kratochwill, T.R. (1992). Behavioral parent-teacher consultation: Conceptual and research considerations. Journal of School Psychology, 30,

Sheridan, S.M., Kratochwill, T.R., & Bergan, J.R. (1992). Conjoint Behavioral Consultation: Practitioner Guidebook. New York: Plenum Press.

Sloane, H.N., Endo, G.T., Hawkes, T.W., & Jenson, W.R. (1990). Decreasing children's fighting through self-instructional parent training materials. School Psychology, 11, 17-29.

Tawney, J., & Gast, D. (1984). Single subject research in special education. Columbus, Ohio: Merrill Publishing.

Wampold, B.E., & Worsham, N.L. (1986). Randomization Tests for Multiple-Baseline Designs, Behavioral Assessment, 8, 135-143.

Watson, T.S., Sterling, H.E., & McDade, A. (1997). Demystifying Behavior Consultation. School Psychology Review, 26, 467-474.

Weathers, L., & Liberman. R.P. (1975). The family contracting exercise. Journal of Behavior Therapy and Experimental Psychiatry, 6, 208-214.

Webster-Stratton, C. (1996).

Webster-Stratton, C. (1992). Individually administered videotape parent training: "Who benefits?" Cognitive Therapy and Research, 16, 31-35.

Webster-Stratton, C. (1990). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. Journal of Abnormal Child Psychology, 18, 479-492.

Webster-Stratton, C., & Hancock, L. (In press). Parent Training for Parents of Young Children with Conduct Problems: Content, Methods and Therapeutic Processes. In C.E. Schaefer (Ed.), Handbook of Parent Training.

Webster-Stratton, C., Hollinsworth, T., & Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. Journal of Consulting and Clinical Psychology, 57, 550-553.

Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. Journal of Consulting and Clinical Psychology, 56, 558-566.

Zins, J.E. (1984). A scientific problem-solving approach to developing accountability procedures for school psychologists. Professional Psychology Research and Practice, 15, 56-66.

APPENDICES

Appendix A

Consent Forms

PARENTAL CONSENT FOR SCREENING PARTICIPATION

We are interested in helping young children who are having problems interacting with other children. These children may benefit from out program, the Parent-Teacher Intervention Project (P-TIP). The purpose of this program is to help children to get along with other children. The Social Skills Rating System (SSRS) is a questionnaire that helps us to identify children that may benefit from our services. If the assessment indicated that your child could profit from the P-TIP, he or she may become involved in the project, with your approval.

This program is being conducted by professors and advanced graduate students in School Psychology at the University of Wisconsin-Madison. Dr. Thomas R. Kratochwill and Dr. Stephen N. Elliott, both from the Department of Educational Psychology, are directing this project. The project is also part of a dissertation being conducted by Pam Loitz, a graduate student in the Department of Educational Psychology. The research has received university approval and involves minimal or no risks for participants. Participation is voluntary, and you or your child may withdraw from the project at any time, without penalty or loss of benefit. The confidentiality of your identity, as well as your child's, will be protected in any reports of the project. All information obtained on children is maintained in secure files and no information is released to any party without your written consent. No child is identified in any report of the project.

At this time, we are interested in identifying children who, from the parents' perspective, may benefit from this program. To do this we are asking you to take 15 minutes to complete the parent version of the SSRS. Based on your ratings, we may ask your child's teacher to fill out the SSRS later this fall. By signing below, you are agreeing to participate in the screening or identification process, and giving us permission to contact your child's teacher at a later date.

If your child qualifies for this project, an advanced graduate student in school psychology will serve as a consultant to you and your child's teacher during the school year. The student will meet with you and your child's teacher to discuss specific difficulties your child is having, suggest ways to improve your child's behavior, and evaluate the effects of the program. The benefit of your participation is that you will learn skills to help your child. You would, again, be asked to give permission for this phase of the project.

If you have any further questions about these procedures, please contact your child's teacher. Dr. Thomas Kratochwill and Dr. Stephen Elliott, Professors in the School Psychology Program and Ms. Sherry Robertson, a student in School Psychology, are the investigators of the research project. Please feel free to contact them at any time with questions about the project or procedures. They may be reached through the project secretary (263-5795).

Thank you for your time!

_____
Child's name

_____ _____
Parent's signature Date

_____ _____
Parent's signature Date

PARENT CONSENT FOR SCREENING PARTICIPATION
IN THE PARENT-TEACHER INTERVENTION PROJECT

I acknowledge being informed to my satisfaction of the goals, benefits, risks, and procedures of the screening phase of the Parent-Teacher Intervention Project, and agree to participate. I understand that confidentiality of my identity, as well as the identity of my child will be protected in any discussion of reports of this project. I also understand that I may withdraw my participation at any time.

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date

TEACHER CONSENT FOR SCREENING PARTICIPATION

Dear Head Start Teacher,

Recently, the parents of _____ completed the Social Skills Rating System (SSRS) during the Head Start screening week. The results of that assessment indicate that the parents and child may benefit from the Parent-Teacher Intervention Project (P-TIP), a research project whose goals are to: (a) provide consultation services to parents and teachers, thereby encouraging a cooperative problem-solving venture between the two; (b) work collaboratively with parents and teachers to address specific difficulties of withdrawn children and children with behavior problems; and (c) implement an effective behavioral program to remediate the difficulties exhibited by the children.

This program is being conducted by professors and advanced graduate students in School Psychology at the University of Wisconsin-Madison. Dr. Thomas R. Kratochwill, and Dr. Stephen N. Elliott, both from the Department of Educational Psychology, are directing this project. This project is also part of a dissertation being conducted by Pam Loitz, a graduate student in the Department of Educational Psychology. The research has received university approval and involves minimal or no risks for participants. Participation is voluntary, and you or your child may withdraw from the project at any time, without penalty or loss of benefit. The confidentiality of your identity, as well as your child's identity will be protected in any reports of the project. All information obtained on children is maintained in secure files and no information is released to any party without your written consent. No child is identified in any report of the project.

At this time, we are interested in identifying children, from a teachers perspective who may benefit from this program. To do this we are asking you to take 30 minutes to complete the teacher version of the SSRS and to complete the Child Behavior Checklist. **By signing below, you are agreeing to participate in the screening or identification process, and give us permission to contact you at a later date.**

If the child named above qualifies for this project, an advanced graduate student in school psychology will serve as a consultant to you and the child's parents during the school year. The student will meet with you and the parents to discuss specific difficulties the child is having, suggest ways to improve the child's behavior, and evaluate the effects of the program. The benefit of your participation is that you will learn skills that will benefit the child named above, while also learning strategies that may benefit other children in your class.

BEST COPY AVAILABLE

If you have any further questions, please contact your child's teacher. Dr. Thomas Kratochwill and Dr. Stephen Elliott, Professors in the School Psychology Program and Ms. Sherry Robertson, student in School Psychology, are the investigators of the research project. Please feel free to contact any one of them at any time with questions about the project or procedures. They may be reached through the project secretary (263-5795).

Thank-you for your time!

enc: Consent Form

Teacher Consent Form

P-TIP 1994-95

Please check one:

____ I agree to participate in the screening and assessment of the above named student.

____ I do not wish to participate in the screening and assessment component of your project.

_____ _____

Teacher's Signature Date

October 1, 1994

Dear Parent:

The purpose of this document is to review the responsibilities of the parent(s) in the Parent-Teacher Intervention Project. This project is funded for 5 years by the U.S. Office of Education and is designed to assist parents and teachers who have specific behavioral concerns with children at home or in the classroom. The project is specifically designed to serve children with either conduct/acting out difficulties or socially withdrawn behaviors.

This research project is being conducted by two professors, Drs. Thomas R. Kratochwill and Stephen N. Elliott, and several advanced graduate students in the School Psychology area at the University of Wisconsin-Madison. The project is also part of a dissertation being conducted by Pam Loitz, a graduate student in the Department of Educational Psychology. The research has received approval from the University of Wisconsin Human Subjects Committee and involves minimal or no risks for participants.

The specific goals of the project are: (a) to provide consultative services to parents and teachers, thereby encouraging a cooperative problem-solving venture between the two; (b) to work collaboratively with parents and teachers to address the specific behavioral difficulties of children; and (c) to implement an effective behavioral program to remediate the difficulties exhibited by the nominated child.

Participating parent(s) will be asked to assist in program implementation at various levels. Among the responsibilities of the parent are the following:

1. Assist in monitoring your child's progress by completing the Social Skills Rating System checklist and Child Behavior Checklist. This will require approximately 40 minutes of your time.

2. Meet with the consultant and your child's teacher to discuss your child's possible inclusion in the program, review the program procedures in greater detail, and enlist cooperation and participation of the teacher.

3. Meet with the consultant for regular interviews, in which specific concerns can be discussed, treatment goals and objectives can be established and program procedures can be evaluated.

4. Conduct an interview with your child and the consultant in which the program is explained and your child's agreement to participate is obtained.

5. Implement and help monitor a behavioral program or treatment component that addresses the specific behaviors that your child exhibits. The treatment program will consist of a comprehensive video-based program for parents and teachers. The program includes a manual and 9 video cassettes divided into four programs: (1) Play, (2) Praise and Rewards, (3) Effective Limit Setting, and (4) Handling Misbehavior. The manual contains an introduction to the content of each video cassette and a summary of points to remember, while the videotapes illustrate essential child management concepts by displaying brief vignettes of parents interacting with children in various situations.

Parents should have access to a video machine (VCR) to facilitate the treatment program.

If you agree to participate, please sign the form below. Parents should be aware that not all children nominated for services will qualify and some who qualify may not receive treatment services. Those who are not treated will receive a comprehensive assessment, which could be used by other agencies or personnel. If you have any questions regarding the project, please contact your child's teacher. Dr. Thomas Kratochwill and Dr. Stephen Elliott, Professors in the School Psychology Program and Ms. Sherry Robertson, a student in School Psychology, are the investigators of the research project. Please feel free to contact any one of them at any time with questions about the project or procedures. They may be reached through the project secretary (263-5795).

PARENT CONSENT FOR PARTICIPATION
IN THE PARENT-TEACHER INTERVENTION PROJECT

I acknowledge being informed to my satisfaction of the goals, benefits, risks, and procedures of the Parent-Teacher Intervention Project. It is my understanding that the procedures will involve:

1. Interviews and meetings with myself, the consultant, and my child's teacher.

2. The completion of brief rating forms to provide information about my child's progress and my involvement in the treatment program.

3. Classroom observations of my child with his/her friends.

4. The teaching of skills using a videotape program that contains four main techniques, including: (a) play, (b) praise and rewards, (c) effective limit setting and, (d) handling misbehavior.

5. Having access to a video machine (VCR) to facilitate involvement in treatment implementation.

I understand that confidentiality of my child's identity is assured, and will not be reported in any formal discussion or publication of the project. I also understand that I may withdraw myself and my child from the program at any time

_____
Child's Name

_____ _____
Parent Signature Date

BEST COPY AVAILABLE

October 1, 1994

Dear Head Start Teacher:

The purpose of this document is to review the involvement of the teacher in the Parent-Teacher Intervention Project. This project is funded for 5 years by the U.S. Office of Education and is designed to assist teachers who have specific behavioral concerns with children in their classroom. The project is specifically designed to serve children with either conduct/acting out difficulties or socially withdrawn behaviors.

This research project is being conducted by two professors, Drs. Thomas R. Kratochwill and Stephen N. Elliott, and several advanced graduate students in the School Psychology area at the University of Wisconsin-Madison. This project is also part of a dissertation being conducted by Pam Loitz, a graduate student in the Department of Educational Psychology. The research has received approval from the University of Wisconsin Human Subjects Committee and involves minimal or no risks for participants.

The specific goals of the project are (a) to provide consultative services to parents and teachers, thereby encouraging a cooperative problem-solving venture between the two, (b) to work collaboratively with parents and teachers to address the specific behavioral difficulties of children, and (c) to implement an effective behavioral program to remediate the difficulties exhibited by the nominated child.

Participating teachers will be asked to assist in program implementation at various levels. Among the responsibilities of the teacher are the following:

1. Assist in the screening of students by completing the Social Skills Rating System checklist and Child Behavior Checklist. This task will require approximately 40 minutes of your time.

2. Meet with the consultant and the child's teacher to discuss the child's possible inclusion in the program, review the program procedures in greater detail, and enlist cooperation and participation of the parents.

3. Meet with the consultant for regular interviews, in which specific concerns can be discussed, treatment goals and objectives can be established, and program procedures can be evaluated.

4. Conduct an interview with the child and the consultant in which the program is explained and the child's agreement to participate is obtained.

5. Implement a treatment program that is based on a comprehensive video-based series that contains four main techniques including: (a) play, (b) praise and rewards, (c) effective limit setting, and (d) handling misbehavior.

If you agree to participate, please sign the form below and return it to Ms. Barb Knipfer. Teachers should be aware that not all children nominated for services will qualify and some who qualify may not receive treatment services. Those who are not treated will receive an assessment, which could be used by other agencies or personnel. If your have any questions regarding the project, please contact your child's teacher. Dr. Thomas Kratochwill and Dr. Stephen Elliott, Professors in the School Psychology Program and Ms. Sherry Robertson, a student in School Psychology, are the investigators of the research project. Please feel free to contact any one of them at any time with questions about the project or procedures. They may be reached through the project secretary (263-5795).

BEST COPY AVAILABLE

TEACHER CONSENT FOR PARTICIPATION
IN THE PARENT TEACHER INTERVENTION PROJECT

I acknowledge being informed to my satisfaction of the goals, benefits, risks, and procedures of the Parent Teacher Intervention Project, and agree to participate. I understand that confidentiality of my identity, as well as the identity of the student and his/her parents will be protected in any discussion of reports of this project. I also understand that I may withdraw my participation at any time.

_____ _____

Teacher's Signature Date

Appendix B

Observation Protocols

P-TIP OBSERVATION FORM
(1993-94)

Student: _____ Teacher: _____

School/Site: _____ Consultant: _____

Date: _____ Time Started: _____ Time Finished: _____

Observation Situation: _____

Observer #1: _____ Observer #2: _____

Observation Codes & Behavior Definitions

Social Engagement (SE+,SE 0, SE-): refers to an exchange of social signals between two or more children or the target child and an adult that involves either verbal or nonverbal interactions. Social engagement is coded when the target child is physically oriented toward another person and is exchanging social signals of a reciprocal nature with the other person(s).

Not Codeable (NC): is used when the target child's behavior cannot be accurately coded because the child is out of sight.

Target Behavior #1 (TB1): _____

_____

_____

Target Behavior #2 (TB2): _____

_____

_____

BEST COPY AVAILABLE

Target Child: _____ Date: _____ Page: ___

Child T or C	TB#1	TB#2	SE (+,0,-)	NC	Comments
T 1					
C 2					
T 3					
C 4					
T 5					
C 6					
T 7					
C 8					
T 9					
C10					
T11					
C12					
T13					
C14					
T15					
C16					
T17					
C18					
T19					
C20					
T21					
C22					
T23					
C24					
T25					
C26					
T27					
C28					
T29					
C30					

Target Child: _____ Date: _____ Page: ___

Child T or C	TB#1	TB#2	SE (+,0,-)	NC	Comments
T31					
C32					
T33					
C34					
T35					
C36					
T37					
C38					
T39					
C40					
T41					
C42					
T43					
C44					
T45					
C46					
T47					
C48					
T49					
C50					
T51					
C52					
T53					
C54					
T55					
C56					
T57					
C58					
T59					
C60					

Target Child: _____ Date: _____ Page: ___

Child T or C	TB#1	TB#2	SE (+,0,-)	NC	Comments
T61					
C62					
T63					
C64					
T65					
C66					
T67					
C68					
T69					
C70					
T71					
C72					
T73					
C74					
T75					
C76					
T77					
C78					
T79					
C80					
T81					
C82					
T83					
C84					
T85					
C86					
T87					
C88					
T89					
C90					

Social Behavior Ratings

Based on your observation of the target student today, please rate how often the student exhibited each of the 40 behaviors listed below. In cases where you may not have observed the student performing a particular behavior, please estimate the degree to which you think the student would perform the behavior. Mark any estimates with a letter 'e' next to the item number.

FOR OFFICE USE ONLY				How Often?		
C	A	S		Never	Sometimes	Very Often
			1. Follows your directions.	0	1	2
			2. Makes friends easily.	0	1	2
			3. Appropriately tells you when he or she thinks you have treated him or her unfairly.	0	1	2
			4. Responds appropriately to teasing by peers.	0	1	2
			5. Appropriately questions rules that may be unfair.	0	1	2
			6. Attempts classroom tasks before asking for your help.	0	1	2
			7. Controls temper in conflict situations with adults.	0	1	2
			8. Gives compliments to peers.	0	1	2
			9. Participates in games or group activities.	0	1	2
			10. Produces correct schoolwork.	0	1	2
			11. Helps you without being asked.	0	1	2
			12. Introduces himself or herself to new people without being told.	0	1	2
			13. Accepts peers' ideas for group activities.	0	1	2
			14. Cooperates with peers without prompting.	0	1	2
			15. Waits turn in games or other activities.	0	1	2
			16. Uses time appropriately while waiting for your help.	0	1	2
			17. Says nice things about himself or herself when appropriate.	0	1	2
			18. Uses free time in an acceptable way.	0	1	2
			19. Acknowledges compliments or praise from peers.	0	1	2
			20. Controls temper in conflict situations with peers.	0	1	2
			21. Follows rules when playing games with others.	0	1	2
			22. Finishes class assignments within time limits.	0	1	2
			23. Compromises in conflict situations by changing own ideas to reach agreement.	0	1	2
			24. Initiates conversations with peers.	0	1	2
			25. Invites others to join in activities.	0	1	2
			26. Receives criticism well.	0	1	2
			27. Puts work materials or school property away.	0	1	2
			28. Responds appropriately to peer pressure.	0	1	2
			29. Joins ongoing activity or group without being told to do so.	0	1	2
			30. Volunteers to help peers with classroom tasks.	0	1	2
C	A	S	SUMS OF HOW OFTEN COLUMNS			

FOR OFFICE USE ONLY		How Often?		
E	I	Never	Sometimes	Very Often
	31. Has temper tantrums.	0	1	2
	32. Fidgets or moves excessively.	0	1	2
	33. Argues with others.	0	1	2
	34. Disturbs ongoing activities.	0	1	2
	35. Says nobody likes him or her.	0	1	2
	36. Appears lonely.	0	1	2
	37. Is aggressive toward people or objects.	0	1	2
	38. Disobeys rules or requests.	0	1	2
	39. Shows anxiety about being with a group of children.	0	1	2
	40. Acts sad or depressed.	0	1	2
E	SUMS OF HOW OFTEN COLUMNS			

Stop. Please check to be sure all items have been marked.

BEST COPY AVAILABLE

Scoring Sheet

Student: _____ Teacher: _____

School/Site: _____ Consultant: _____

Date: _____ Observer: _____

Observations _____

	TB#1	TB#2	SE+	SEo	SE-	NC
p.1 subtotals	____	____	____	____	____	____
p.2 subtotals	____	____	____	____	____	____
p.3 subtotals	____	____	____	____	____	____
TOTALS Freq	____	____	____	____	____	____
%	____	____	____	____	____	____

SSRS RATINGS _____

SUMMARY

SOCIAL SKILLS

HOW OFTEN? TOTAL (sums from p. 2) (sums from p. 3)

BEHAVIOR LEVEL *(see Appendix A)* Fewer Average More

C + + | A + + | S + + | Total (C + A + S)

(see Appendix B)

Standard Score ☐ Percentile Rank ☐

(see Appendix E)

SEM ± ☐ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ☐ to ☐

PROBLEM BEHAVIORS

HOW OFTEN? TOTAL (sums from page 3)

BEHAVIOR LEVEL *(see Appendix A)* Fewer Average More

E | I | Total (E + I)

(see Appendix B)

Standard Score ☐ Percentile Rank ☐

(see Appendix E)

SEM ± ☐ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ☐ to ☐

BEST COPY AVAILABLE

Appendix C

Child Behavior Checklist

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For office use only
ID #

CHILD'S NAME

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Date ____ Yr. ____

CHILD'S BIRTHDATE Mo. ____ Date ____ Yr. ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: ____

MOTHER'S TYPE OF WORK: ____

THIS FORM FILLED OUT BY:

☐ Mother (name): ____

☐ Father (name): ____

☐ Other—name & relationship to child: ____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a. ____	☐	☐	☐	☐
b. ____	☐	☐	☐	☐
c. ____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐
b. ____	☐	☐	☐	☐
c. ____	☐	☐	☐	☐

Copyright 1991 T.M. Achenbach, U. of Vermont

BEST COPY AVAILABLE

V. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more
(Do not include brothers & sisters)

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do not include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work by himself/herself?	☐	☐	☐	

VII. 1. For ages 6 and older—performance in academic subjects. If child is not being taught, please give reason _____

	Failing	Below average	Average	Above average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects—for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Is your child in a special class or special school? ☐ No ☐ Yes—what kind of class or school?

3. Has your child repeated a grade? ☐ No ☐ Yes—grade and reason

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe

When did these problems start?

Have these problems ended? ☐ No ☐ Yes—when?

Does your child have any illness, physical disability, or mental handicap? ☐ No ☐ Yes—please describe

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food — *don't* include sweets (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems without known medical cause:
0 1 2 a. Aches or pains (*not* headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe): _____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe): _____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Appendix D

Teacher Report Form

TEACHER'S REPORT FORM

For office use only
ID #

Your answers will be used to compare the pupil with other pupils whose teachers have completed similar forms. The information from this form will also be used for comparison with other information about this pupil. Please answer as well as you can, even if you lack full information. Scores on individual items will be combined to identify general patterns of behavior. Feel free to write additional comments beside each item and in the spaces provided on page 2.

PUPIL'S NAME			PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be as specific as you can—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*
PUPIL'S SEX ☐ Boy ☐ Girl	PUPIL'S AGE	ETHNIC GROUP OR RACE	FATHER'S TYPE OF WORK: _____
TODAY'S DATE Mo.____ Date____ Yr.____	PUPIL'S BIRTHDATE (if known) Mo.____ Date____ Yr.____		MOTHER'S TYPE OF WORK: _____
GRADE IN SCHOOL	NAME OF SCHOOL		THIS FORM FILLED OUT BY: ☐ Teacher (name) _____ ☐ Counselor (name) _____ ☐ Other (specify) name: _____

I. How long have you known this pupil?_____ months

II. How well do you know him/her? 1. ☐ Not Well 2. ☐ Moderately Well 3. ☐ Very Well

III. How much time does he/she spend in your class per week?

IV. What kind of class is it? (Please be specific, e.g., regular 5th grade, 7th grade math, etc.)

V. Has he/she ever been referred for special class placement, services, or tutoring?
☐ Don't Know 0. ☐ No 1. ☐ Yes—what kind and when?

VI. Has he/she ever repeated a grade?
☐ Don't Know 0. ☐ No 1. ☐ Yes—grade and reason

VII. Current school performance—list academic subjects and check column that indicates pupil's performance:

Academic subject	1. Far below grade	2. Somewhat below grade	3. At grade level	4. Somewhat above grade	5. Far above grade
1. _____	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐
4. _____	☐	☐	☐	☐	☐
5. _____	☐	☐	☐	☐	☐
6. _____	☐	☐	☐	☐	☐

©Copyright 1991 Thomas M. Achenbach
Center for Children, Youth, & Families
University of Vermont

UNAUTHORIZED REPRODUCTION FORBIDDEN BY LAW

1/91 Edition

131

BEST COPY AVAILABLE

VIII. Compared to typical pupils of the same age:	1. Much less	2. Somewhat less	3. Slightly less	4. About average	5. Slightly more	6. Somewhat more	7. Much more
1. How hard is he/she working?	☐	☐	☐	☐	☐	☐	☐
2. How appropriately is he/she behaving?	☐	☐	☐	☐	☐	☐	☐
3. How much is he/she learning?	☐	☐	☐	☐	☐	☐	☐
4. How happy is he/she?	☐	☐	☐	☐	☐	☐	☐

IX. Most recent achievement test scores (If available):

Name of test	Subject	Date	Percentile or grade level obtained

X. IQ, readiness, or aptitude tests (If available):

Name of test	Date	IQ or equivalent scores

Does this pupil have any illness, physical disability, or mental handicap? ☐ No ☐ Yes—please describe

What concerns you most about this pupil?

Please describe the best things about this pupil:

Please feel free to write any comments about this pupil's work, behavior, or potential, using extra pages if necessary.

Below is a list of items that describe pupils. For each item that describes the pupil now or within the past 2 months, please circle the 2 if the item is very true or often true of the pupil. Circle the 1 if the item is somewhat or sometimes true of the pupil. If the item is not true of the pupil, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to this pupil.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Hums or makes other odd noises in class
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. Behaves like opposite sex
0 1 2 6. Defiant, talks back to staff
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Fidgets
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys property belonging to others
0 1 2 22. Difficulty following directions
0 1 2 23. Disobedient at school
0 1 2 24. Disturbs other pupils
0 1 2 25. Doesn't get along with other pupils
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food—*don't* include sweets (describe):_____
_____
0 1 2 29. Fears certain animals, situations, or places other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe):
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, high-strung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Overconforms to rules
0 1 2 48. Not liked by other pupils
0 1 2 49. Has difficulty learning
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Talks out of turn
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems without known medical cause:
0 1 2 a. Aches or pains (*not* headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe):_____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe):_____
_____
_____

BEST COPY AVAILABLE

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Sleeps in class
0 1 2 60. Apathetic or unmotivated
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older children or youths
0 1 2 64. Prefers being with younger children
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Disrupts class discipline
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Messy work
0 1 2 73. Behaves irresponsibly (describe): _____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Explosive and unpredictable behavior
0 1 2 77. Demands must be met immediately, easily frustrated
0 1 2 78. Inattentive, easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Feels hurt when criticized
0 1 2 82. Steals
0 1 2 83. Stores up things he/she doesn't need (describe):
_____
_____

0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Underachieving, not working up to potential
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Seems preoccupied with sex
0 1 2 97. Threatens people
0 1 2 98. Tardy to school or class
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Fails to carry out assigned tasks
0 1 2 101. Truancy or unexplained absence
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes describe): _____
_____
0 1 2 106. Overly anxious to please
0 1 2 107. Dislikes school
0 1 2 108. Is afraid of making mistakes
0 1 2 109. Whining
0 1 2 110. Unclean personal appearance
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries

113. Please write in any problems the pupil has that were not listed above:

0 1 2 _____
0 1 2 _____
0 1 2 _____

BEST COPY AVAILABLE

Appendix E

Social Skills Rating System - Teacher Form

Frank M. Gresham and Stephen N. Elliott

This questionnaire is designed to measure **how often** a student exhibits certain social skills and **how important** those skills are for success in *your* classroom. Ratings of problem behaviors are also requested. First, complete the information about the student and yourself.

Student information

Student's name_____ Date_____
First Middle Last Month Day Year

School_____ City_____ State_____

Grade_____ Birth date_____ Sex: ☐ Female ☐ Male
Month Day Year

Ethnic group (optional)

- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ Indian (Native American)
- ☐ White
- ☐ Other_____

Is this student handicapped? ☐ Yes ☐ No

If handicapped, this student is classified as:

- ☐ Learning-disabled
- ☐ Behavior-disordered
- ☐ Mentally handicapped
- ☐ Other handicap (specify)_____

Teacher information

Teacher's name_____ Sex: ☐ Female ☐ Male
First Middle Last

What is your assignment?

☐ Regular ☐ Resource ☐ Self-contained ☐ Other (specify) _____

AGS
© 1990, American Guidance Service, Inc., Publishers' Building, Circle Pines, MN 55014-1796
All rights reserved. No part of this Questionnaire may be photocopied or otherwise reproduced. This Questionnaire was printed in two colors.
A 10 9 8 7 6 5 4

Form: TP

BEST COPY AVAILABLE

Next, read each item on pages 2 and 3 (items 1 - 40) and think about this student's behavior during the past month or two. Decide **how often** the student does the behavior described.

If the student **never** does this behavior, circle the **0**.
If the student **sometimes** does this behavior, circle the **1**.
If the student **very often** does this behavior, circle the **2**.

For items 1 - 30, you should also rate **how important** each of these behaviors is for success in *your* classroom.

If the behavior is **not important** for success in your classroom, circle the **0**.
If the behavior is **important** for success in your classroom, circle the **1**.
If the behavior is **critical** for success in your classroom, circle the **2**.

Here are two examples:

	How Often?			How Important?		
	Never	Sometimes	Very Often	Not Important	Important	Critical
Shows empathy for peers.	0	1	(2)	0	(1)	2
Asks questions of you when unsure of what to do in schoolwork.	0	(1)	2	0	1	(2)

*This student **very often** shows empathy for classmates. Also, this student **sometimes** asks questions when unsure of schoolwork. This teacher thinks that showing empathy is **important** for success in his or her classroom and that asking questions is **critical** for success.*

Please do not skip any items. In some cases you may not have observed the student perform a particular behavior. Make an estimate of the degree to which you think the student would probably perform that behavior.

FOR OFFICE USE ONLY How Often?			Social Skills	How Often?			How Important?		
C	A	S		Never	Sometimes	Very Often	Not Important	Important	Critical
			1. Follows your directions.	0	1	2	0	1	2
			2. Makes friends easily.	0	1	2	0	1	2
			3. Appropriately tells you when he or she thinks you have treated him or her unfairly.	0	1	2	0	1	2
			4. Responds appropriately to teasing by peers.	0	1	2	0	1	2
			5. Appropriately questions rules that may be unfair.	0	1	2	0	1	2
			6. Attempts classroom tasks before asking for your help.	0	1	2	0	1	2
			7. Controls temper in conflict situations with adults.	0	1	2	0	1	2
			8. Gives compliments to peers.	0	1	2	0	1	2
			9. Participates in games or group activities.	0	1	2	0	1	2
			10. Produces correct schoolwork.	0	1	2	0	1	2
			11. Helps you without being asked.	0	1	2	0	1	2
			12. Introduces himself or herself to new people without being told.	0	1	2	0	1	2
			13. Accepts peers' ideas for group activities.	0	1	2	0	1	2
			14. Cooperates with peers without prompting.	0	1	2	0	1	2
			15. Waits turn in games or other activities.	0	1	2	0	1	2
			16. Uses time appropriately while waiting for your help.	0	1	2	0	1	2
C	A	S	SUMS OF HOW OFTEN COLUMNS						

BEST COPY AVAILABLE

FOR OFFICE USE ONLY How Often?			Social Skills (cont.)	How Often?			How Important?		
C	A	S		Never	Sometimes	Very Often	Not Important	Important	Critical
			17. Says nice things about himself or herself when appropriate.	0	1	2	0	1	2
			18. Uses free time in an acceptable way.	0	1	2	0	1	2
			19. Acknowledges compliments or praise from peers.	0	1	2	0	1	2
			20. Controls temper in conflict situations with peers.	0	1	2	0	1	2
			21. Follows rules when playing games with others.	0	1	2	0	1	2
			22. Finishes class assignments within time limits.	0	1	2	0	1	2
			23. Compromises in conflict situations by changing own ideas to reach agreement.	0	1	2	0	1	2
			24. Initiates conversations with peers.	0	1	2	0	1	2
			25. Invites others to join in activities.	0	1	2	0	1	2
			26. Receives criticism well.	0	1	2	0	1	2
			27. Puts work materials or school property away.	0	1	2	0	1	2
			28. Responds appropriately to peer pressure.	0	1	2	0	1	2
			29. Joins ongoing activity or group without being told to do so.	0	1	2	0	1	2
			30. Volunteers to help peers with classroom tasks.	0	1	2	0	1	2
C	A	S	SUMS OF HOW OFTEN COLUMNS						

FOR OFFICE USE ONLY How Often?		Problem Behaviors	How Often?			
E	I		Never	Sometimes	Very Often	
		31. Has temper tantrums.	0	1	2	Do not make importance ratings for items 31 - 40
		32. Fidgets or moves excessively.	0	1	2	
		33. Argues with others.	0	1	2	
		34. Disturbs ongoing activities.	0	1	2	
		35. Says nobody likes him or her.	0	1	2	
		36. Appears lonely.	0	1	2	
		37. Is aggressive toward people or objects.	0	1	2	
		38. Disobeys rules or requests.	0	1	2	
		39. Shows anxiety about being with a group of children.	0	1	2	
		40. Acts sad or depressed.	0	1	2	
E	I	SUMS OF HOW OFTEN COLUMNS				

Stop. Please check to be sure all items have been marked.

BEST COPY AVAILABLE

FOR OFFICE USE ONLY

SUMMARY

SOCIAL SKILLS

	HOW OFTEN? TOTAL (sums from p. 2)	(sums from p. 3)	BEHAVIOR LEVEL (see Appendix A) Fewer	Average	More
C	+	=			
A	+	=			
S	+	=			
Total (C + A + S)					

(see Appendix B)

Standard Score ____ Percentile Rank ____

(see Appendix E)

SEM ± ____ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ____ to ____

PROBLEM BEHAVIORS

	HOW OFTEN? TOTAL (sums from page 3)	BEHAVIOR LEVEL (see Appendix A) Fewer	Average	More
E				
I				
Total (E + I)				

(see Appendix B)

Standard Score ____ Percentile Rank ____

(see Appendix E)

SEM ± ____ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ____ to ____

Note: To obtain a detailed analysis of this student's Social Skills strengths and weaknesses, complete the Assessment-Intervention Record.

BEST COPY AVAILABLE

Appendix F

Social Skills Rating System - Parent Form

Social Skills

Parent Form
Preschool Level

Rating System

Ages 3-5

Social Skills Questionnaire

Frank M. Gresham and Stephen N. Elliott

Directions

This questionnaire is designed to measure **how often** your child exhibits certain social skills and **how important** those skills are to your child's development. Ratings of problem behaviors are also requested. First, complete the information about your child and yourself.

Student Information

Name _____ Date _____
(First, Middle, Last) (Month, Day, Year)

School _____ City _____ State _____

Grade _____ Birth date _____ Sex: ☐ Female ☐ Male
(Month, Day, Year)

Teacher's name _____

Ethnic group (optional)

☐ Asian ☐ Indian (Native American)
☐ Black ☐ White
☐ Hispanic ☐ Other _____

How many brothers and sisters does this child have at home?

☐ None ☐ 1 ☐ 2 ☐ 3 or more

Parent Information

Name _____ Telephone _____
(First, Middle, Last)

Address _____ City _____ State _____

Sex: ☐ Female ☐ Male

How are you related to this child?

☐ Mother ☐ Guardian
☐ Father ☐ Other _____

AGS®
© 1990, American Guidance Service, Inc., Publishers' Building, Circle Pines, MN 55014-1796
All rights reserved. No part of this Questionnaire may be photocopied or otherwise reproduced. This Questionnaire was printed in two colors.
A 10 9 8 7 6 5 4

Form: PP

141

BEST COPY AVAILABLE

Next, read each item on pages 2-4 (items 1-49) and think about your child's present behavior. Decide **how often** your child does the behavior described.

If your child **never** does this behavior, circle the **0**.
If your child **sometimes** does this behavior, circle the **1**.
If your child **very often** does this behavior, circle the **2**.

For items 1-39, you should also rate **how important** each of these behaviors is for your child's development.

If it is **not important** for your child's development, circle the **0**.
If it is **important** for your child's development, circle the **1**.
If it is **critical** for your child's development, circle the **2**.

Here are two examples:

	How Often?			How Important?		
	Never	Sometimes	Very Often	Not Important	Important	Critical
Shows a sense of humor.	0	1	(2)	0	(1)	2
Answers the phone appropriately.	(0)	1	2	0	1	(2)

*This parent thought that the child **very often** showed a sense of humor and that showing a sense of humor was **important** to the child's development. This parent also thought that the child **never** answered the phone appropriately and that answering the phone appropriately was **critical** to the child's development.*

There are no right or wrong answers. You may take as much time as you like.
Please do not skip any items.

FOR OFFICE USE ONLY How Often? C	A	R	S	Social Skills	How Often? Never	Sometimes	Very Often	How Important? Not Important	Important	Critical
				1. Follows your instructions.	0	1	2	0	1	2
				2. Helps you with household tasks without being asked.	0	1	2	0	1	2
				3. Appropriately questions household rules that may be unfair.	0	1	2	0	1	2
				4. Attempts household tasks before asking for your help.	0	1	2	0	1	2
				5. Gives compliments to friends or other children in the family.	0	1	2	0	1	2
				6. Participates in organized group activities.	0	1	2	0	1	2
				7. Politely refuses unreasonable requests from others.	0	1	2	0	1	2
				8. Introduces herself or himself to new people without being told.	0	1	2	0	1	2
				9. Uses free time at home in an acceptable way.	0	1	2	0	1	2
				10. Asks permission before using another family member's property.	0	1	2	0	1	2
				11. Responds appropriately when hit or pushed by other children.	0	1	2	0	1	2
				12. Volunteers to help family members with tasks.	0	1	2	0	1	2
				13. Invites others to your home.	0	1	2	0	1	2
				14. Avoids situations that are likely to result in trouble.	0	1	2	0	1	2
C	A	R	S	SUMS OF HOW OFTEN COLUMNS						

BEST COPY AVAILABLE

FOR OFFICE USE ONLY How Often? C	A	R	S	Social Skills (cont.)	How Often? Never	Sometimes	Very Often	How Important? Not Important	Important	Critical
				15. Starts conversations rather than waiting for others to talk first.	0	1	2	0	1	2
				16. Keeps room clean and neat without being reminded.	0	1	2	0	1	2
				17. Completes household tasks within a reasonable time.	0	1	2	0	1	2
				18. Controls temper in conflict situations with you.	0	1	2	0	1	2
				19. Controls temper when arguing with other children.	0	1	2	0	1	2
				20. Appropriately expresses feelings when wronged.	0	1	2	0	1	2
				21. Follows rules when playing games with others.	0	1	2	0	1	2
				22. Attends to your instructions.	0	1	2	0	1	2
				23. Shows interest in a variety of things.	0	1	2	0	1	2
				24. Answers the phone appropriately.	0	1	2	0	1	2
				25. Makes friends easily.	0	1	2	0	1	2
				26. Compromises in conflict situations by changing own ideas to reach agreement.	0	1	2	0	1	2
				27. Puts away toys or other household property.	0	1	2	0	1	2
				28. Waits turn in games or other activities.	0	1	2	0	1	2
				29. Receives criticism well.	0	1	2	0	1	2
				30. Congratulates family members on accomplishments.	0	1	2	0	1	2
				31. Follows household rules.	0	1	2	0	1	2
				32. Is self-confident in social situations such as parties or group outings.	0	1	2	0	1	2
				33. Attends to speakers at meetings such as in church or youth groups.	0	1	2	0	1	2
				34. Joins group activities without being told.	0	1	2	0	1	2
				35. Ends disagreements with you calmly.	0	1	2	0	1	2
				36. Is liked by others.	0	1	2	0	1	2
				37. Asks sales clerks for information or assistance.	0	1	2	0	1	2
				38. Communicates problems to you.	0	1	2	0	1	2
				39. Speaks in an appropriate tone of voice at home.	0	1	2	0	1	2
C	A	R	S	SUMS OF HOW OFTEN COLUMNS						

BEST COPY AVAILABLE

Go on to Page 4.

FOR OFFICE USE ONLY How Often? E	I	Problem Behaviors	How Often? Never	Sometimes	Very Often
		40. Has temper tantrums.	0	1	2
		41. Fidgets or moves excessively.	0	1	2
		42. Argues with others.	0	1	2
		43. Disturbs ongoing activities.	0	1	2
		44. Says nobody likes him or her.	0	1	2
		45. Appears lonely.	0	1	2
		46. Is aggressive toward people or objects.	0	1	2
		47. Disobeys rules or requests.	0	1	2
		48. Shows anxiety about being with a group of children.	0	1	2
		49. Acts sad or depressed.	0	1	2
E	I	SUMS OF HOW OFTEN COLUMNS			

Do not make importance ratings for items 40 - 49

Stop. Please check to be sure all items have been marked.

FOR OFFICE USE ONLY

SUMMARY

SOCIAL SKILLS

	HOW OFTEN? TOTAL (sums from p. 2) + (sums from p. 3) =	BEHAVIOR LEVEL (see Appendix A) Fewer	Average	More
C	+ =			
A	+ =			
R	+ =			
S	+ =			
Total (C + A + R + S)				

(see Appendix C)
Standard Score ____ Percentile Rank ____

(see Appendix E)
SEM ± ____ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ____ to ____

PROBLEM BEHAVIORS

	HOW OFTEN? TOTAL (sums from page 4)	BEHAVIOR LEVEL (see Appendix A) Fewer	Average	More
E				
I				
Total (E + I)				

(see Appendix C)
Standard Score ____ Percentile Rank ____

(see Appendix E)
SEM ± ____ Confidence Level 68% ☐ 95% ☐

Confidence Band (standard scores) ____ to ____

BEST COPY AVAILABLE

144

Appendix G

Goal Attainment Scaling

GOAL ATTAINMENT SCALING

Parent-Teacher Intervention Project

Goal attainment scaling (GAS) provides a method for quantifying parents' and teachers' reports of treatment progress with regard to a target behavior and problem situation. Consultants will be responsible for working with parents and teachers to develop a goal attainment scale during the later portion of the PII.

The basic elements of a goal attainment scale are a five-point scale ranging from a +2 to a -2 and descriptions of the target beahvior and problem situation that correspond to the following conditions: Best Possible Behavior (+2), No Change in Behavior (0), and Worst Possible Behavior (-2). The example below illustrates a goal attainment scale for a preschooler who infrequently complies with adult directives to pay attention and to follow directions during transition times.

+2 The child looks at adults when spoken to, listens to their instructions, and almost always (90%) acts accordingly without additional prompts or cues.

+1 The child frequently looks at adults when spoken to, listens to their instructions, and often (60 to 80%) acts accordingly. Some prompts or cues are occasionally needed to get compliance.

0 The child occasionally looks at adults when spoken to, listens to their instructions, and only occasionally (40 to 60%) acts accordingly. Prompts and cues are ususally needed to get this level of compliance.

-1 The child infrequently looks at or listens to adults when spoken to and rarely (20 to 40%) acts accordingly. Strong physical prompts and loud verbal cues are needed to get minimal compliance.

-2 The child virtually never looks at or listens to adults when spoken to and almost always (less than 20%) fails to act accordingly. Strong and repeated physical prompts with loud verbal cues are needed to get any compliance.

By using the numerical ratings for each of the five descriptive categories of behavioral functioning, a consultee should be able to provide a weekly report of treatment progress. These data ideally should accompany other more direct indicators of progress (e.g., direct observations).

GOAL ATTAINMENT SCALE WORKSHEET

Parent Report

Parent-Teacher Intervention Project
(Kratochwill & Elliott, 1993)

Student's Name: _____ **Date:** _____

Parent: _____ **Teacher:** _____

Consultant: _____ **Site:** _____

Target Behavior: _____

+2 _____

_____

+1 _____

_____

0 _____

_____

-1 _____

_____

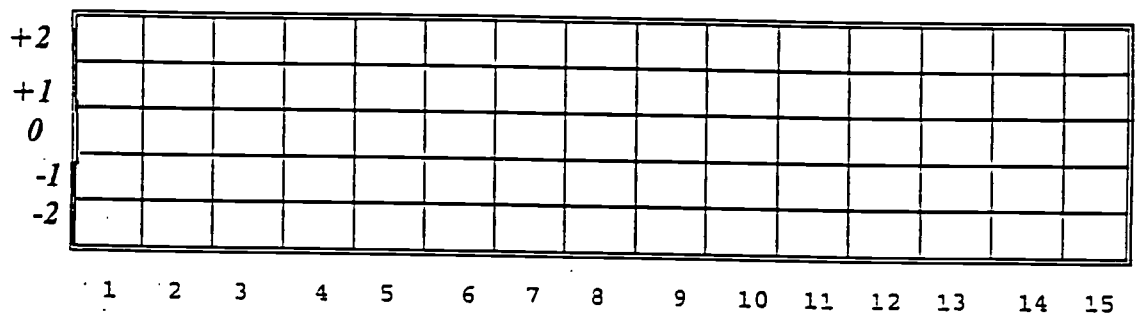
-2 _____

_____

GAS PROGRESS REPORT

Student: _____ Reporter: _____

Consultant: _____ Site: _____



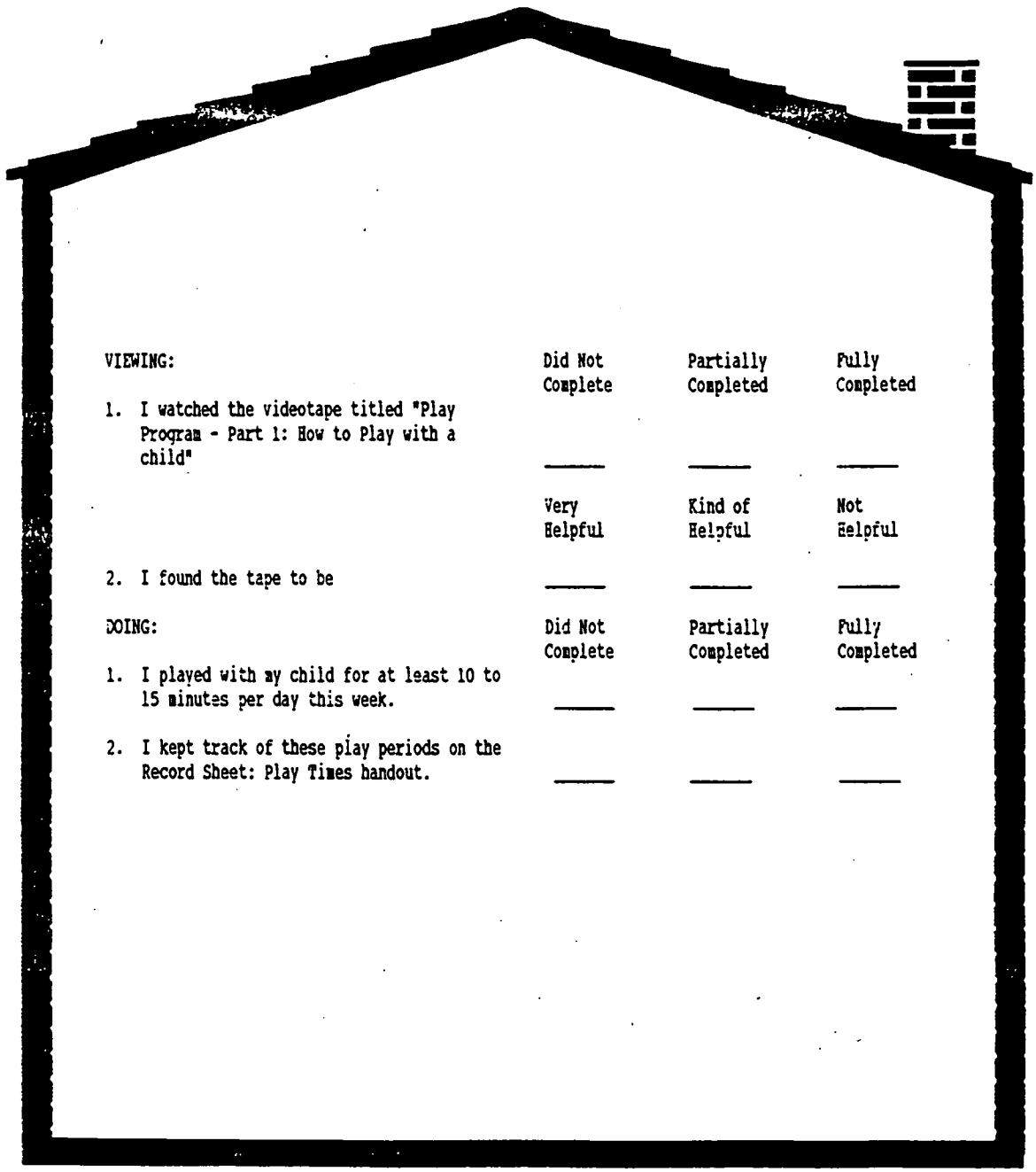
Appendix H

Treatment Integrity Forms

Session One: How to Play with Your Child

"Promoting Your Child's Self-esteem and Encouraging Cooperation"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Play Program - Part 1: How to Play with a child"	_____	_____	_____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	_____	_____	_____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I played with my child for at least 10 to 15 minutes per day this week.	_____	_____	_____
2. I kept track of these play periods on the Record Sheet: Play Times handout.	_____	_____	_____

PTIP 94-95

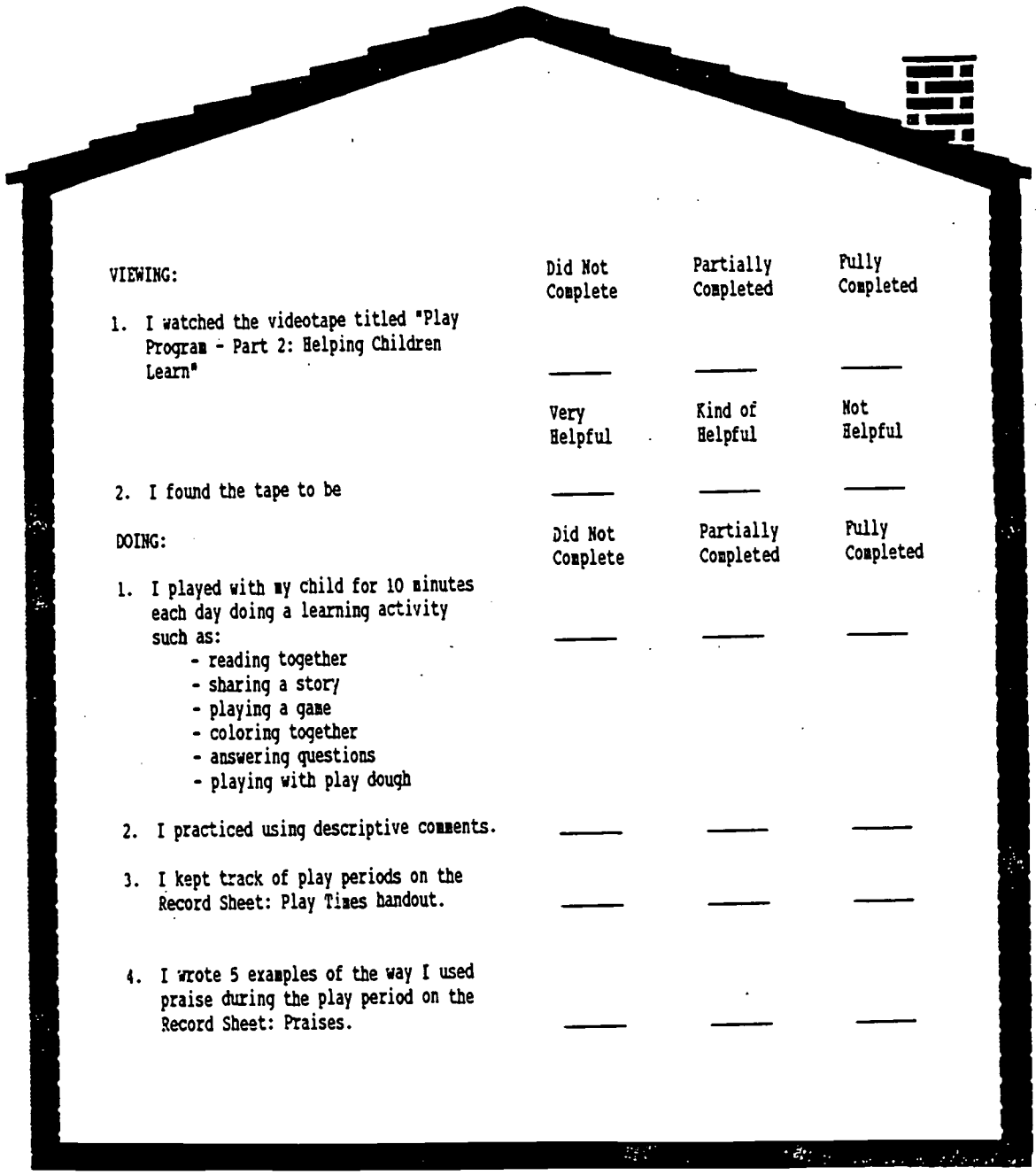
Parent's Name _____ Date _____

BEST COPY AVAILABLE

Session Two: Helping Your Child Learn Through Play

"Promoting Your Child's Thinking Skills"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Play Program - Part 2: Helping Children Learn"	____	____	____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	____	____	____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I played with my child for 10 minutes each day doing a learning activity such as: - reading together - sharing a story - playing a game - coloring together - answering questions - playing with play dough	____	____	____
2. I practiced using descriptive comments.	____	____	____
3. I kept track of play periods on the Record Sheet: Play Times handout.	____	____	____
4. I wrote 5 examples of the way I used praise during the play period on the Record Sheet: Praises.	____	____	____

Person's Name _____ Date _____

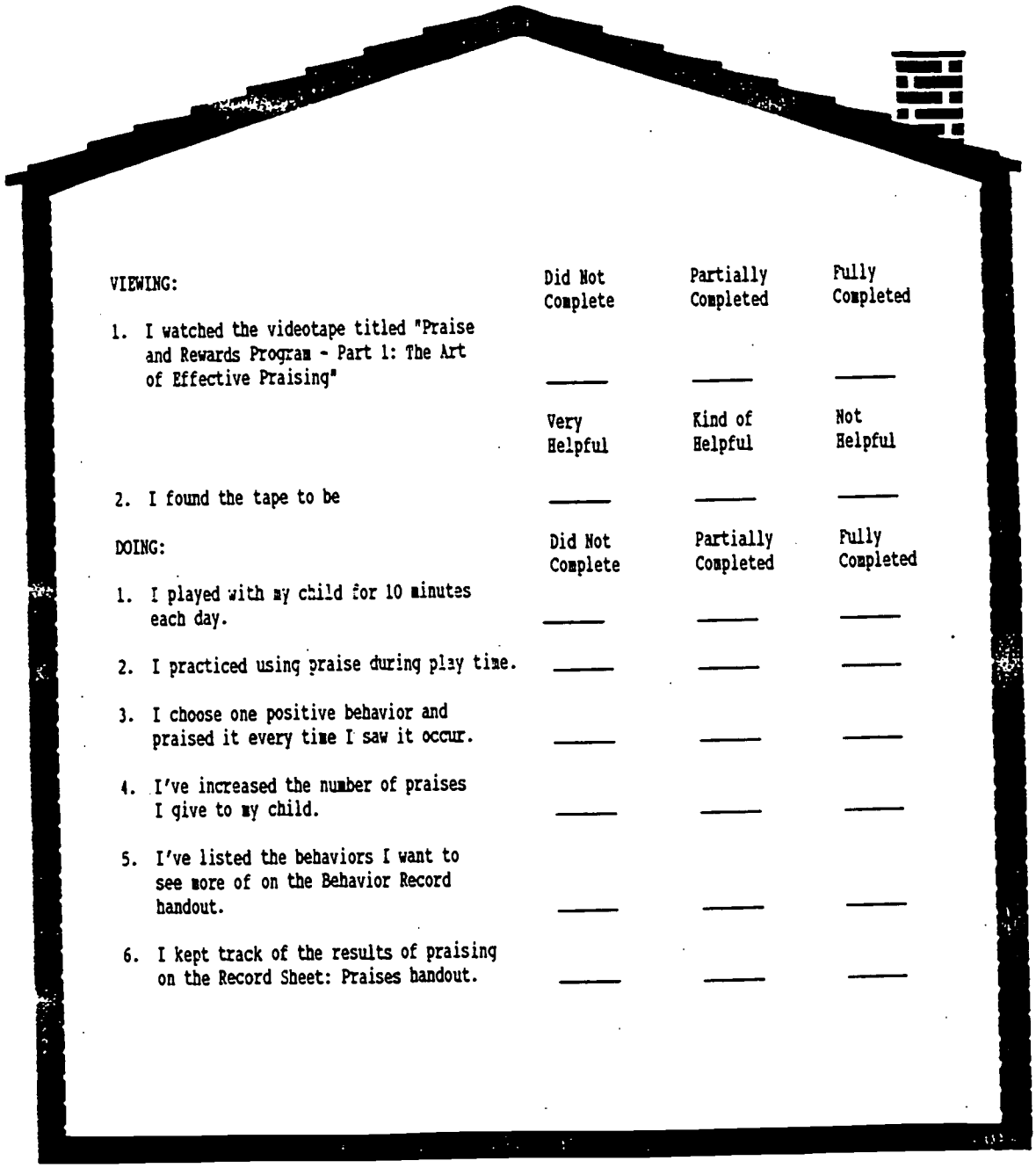
PTIP 94-95

BEST COPY AVAILABLE

Session Three: Effective Ways to Praise and Encourage Your Child

"Bringing Out the Best in Your Child"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Praise and Rewards Program - Part 1: The Art of Effective Praising"	____	____	____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	____	____	____

DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I played with my child for 10 minutes each day.	____	____	____
2. I practiced using praise during play time.	____	____	____
3. I choose one positive behavior and praised it every time I saw it occur.	____	____	____
4. I've increased the number of praises I give to my child.	____	____	____
5. I've listed the behaviors I want to see more of on the Behavior Record handout.	____	____	____
6. I kept track of the results of praising on the Record Sheet: Praises handout.	____	____	____

Parent's Name _____ Date _____

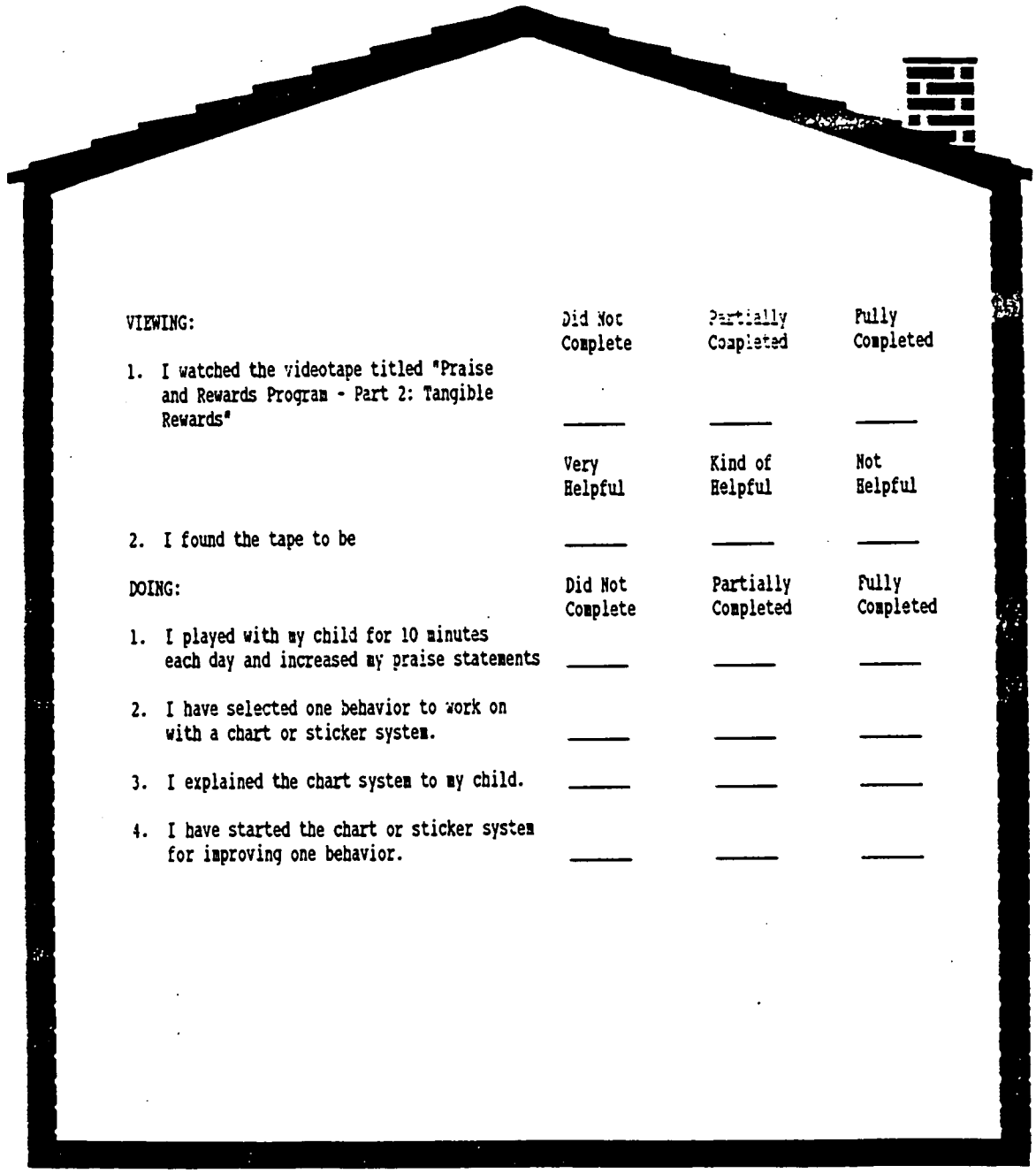
PTIP 94-95

BEST COPY AVAILABLE

Session Four: Using Tangible Reward Programs to Teach
Your Child New Behaviors

"Motivating Your Children"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Praise and Rewards Program - Part 2: Tangible Rewards"	_____	_____	_____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	_____	_____	_____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I played with my child for 10 minutes each day and increased my praise statements	_____	_____	_____
2. I have selected one behavior to work on with a chart or sticker system.	_____	_____	_____
3. I explained the chart system to my child.	_____	_____	_____
4. I have started the chart or sticker system for improving one behavior.	_____	_____	_____

Parent's Name _____ Date _____

PTIP 94-95

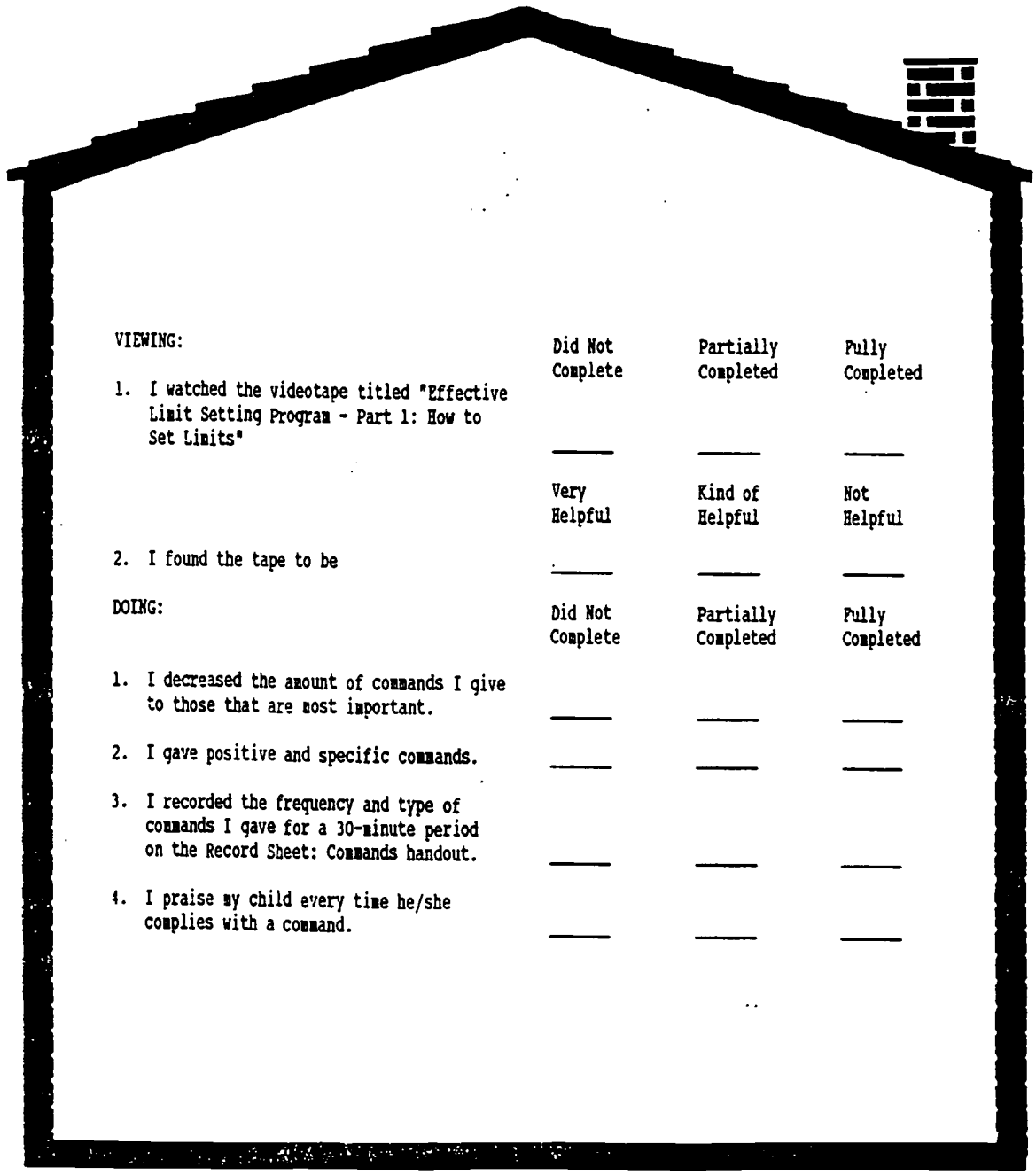
BEST COPY AVAILABLE

BEST COPY AVAILABLE

Session Five: Effective Limit Setting

"The Importance of Being Clear, Predictable, and Positive"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Effective Limit Setting Program - Part 1: How to Set Limits"	____	____	____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	____	____	____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I decreased the amount of commands I give to those that are most important.	____	____	____
2. I gave positive and specific commands.	____	____	____
3. I recorded the frequency and type of commands I gave for a 30-minute period on the Record Sheet: Commands handout.	____	____	____
4. I praise my child every time he/she complies with a command.	____	____	____

Parent's Name _____ Date _____

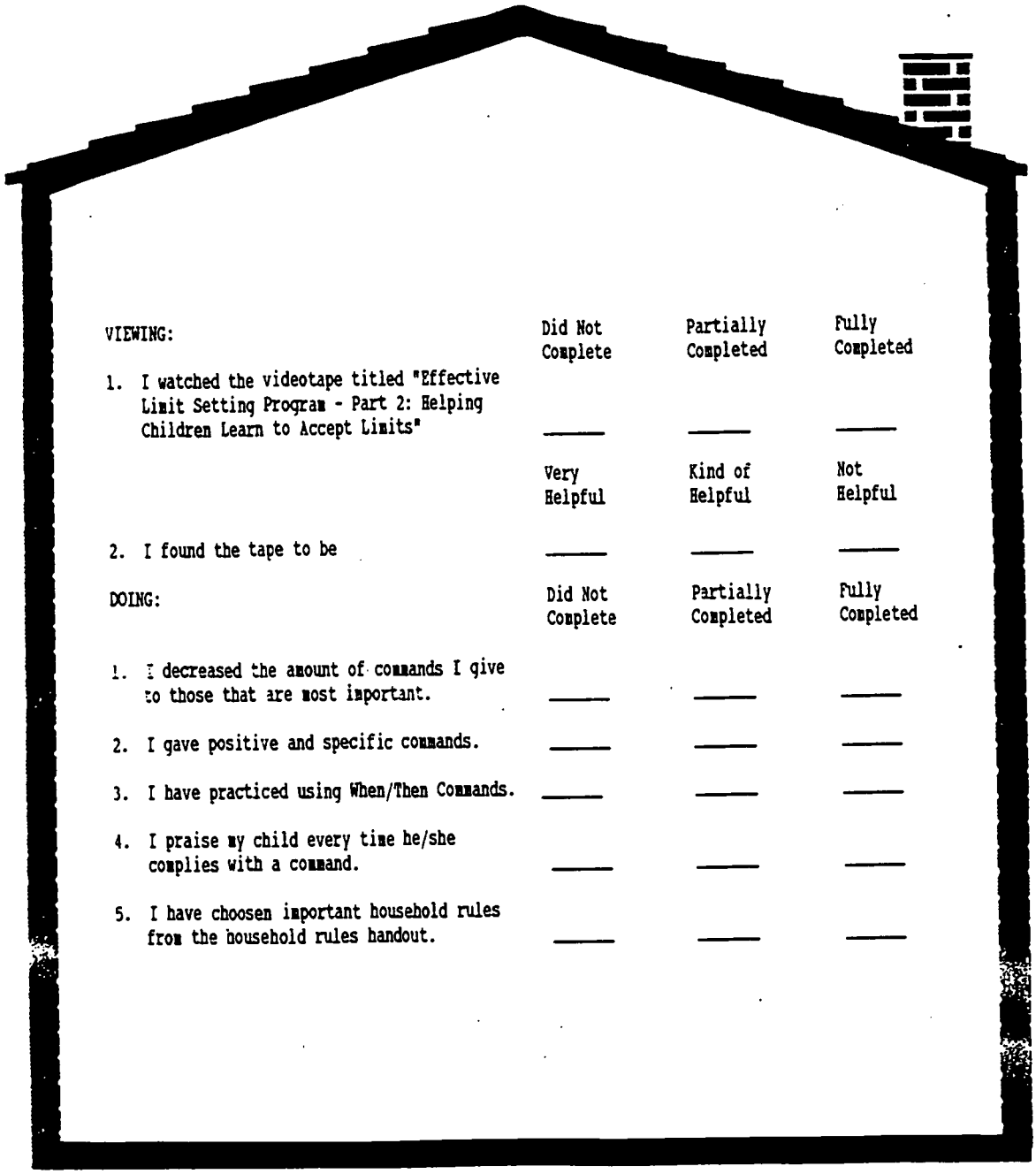
PTIP 94-95

BEST COPY AVAILABLE

Session Six: Effective Limit Setting

"Accepting Limits and Rules"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Effective Limit Setting Program - Part 2: Helping Children Learn to Accept Limits"	_____	_____	_____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	_____	_____	_____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I decreased the amount of commands I give to those that are most important.	_____	_____	_____
2. I gave positive and specific commands.	_____	_____	_____
3. I have practiced using When/Then Commands.	_____	_____	_____
4. I praise my child every time he/she complies with a command.	_____	_____	_____
5. I have choosen important household rules from the household rules handout.	_____	_____	_____

_____ _____ PTIP 94-95

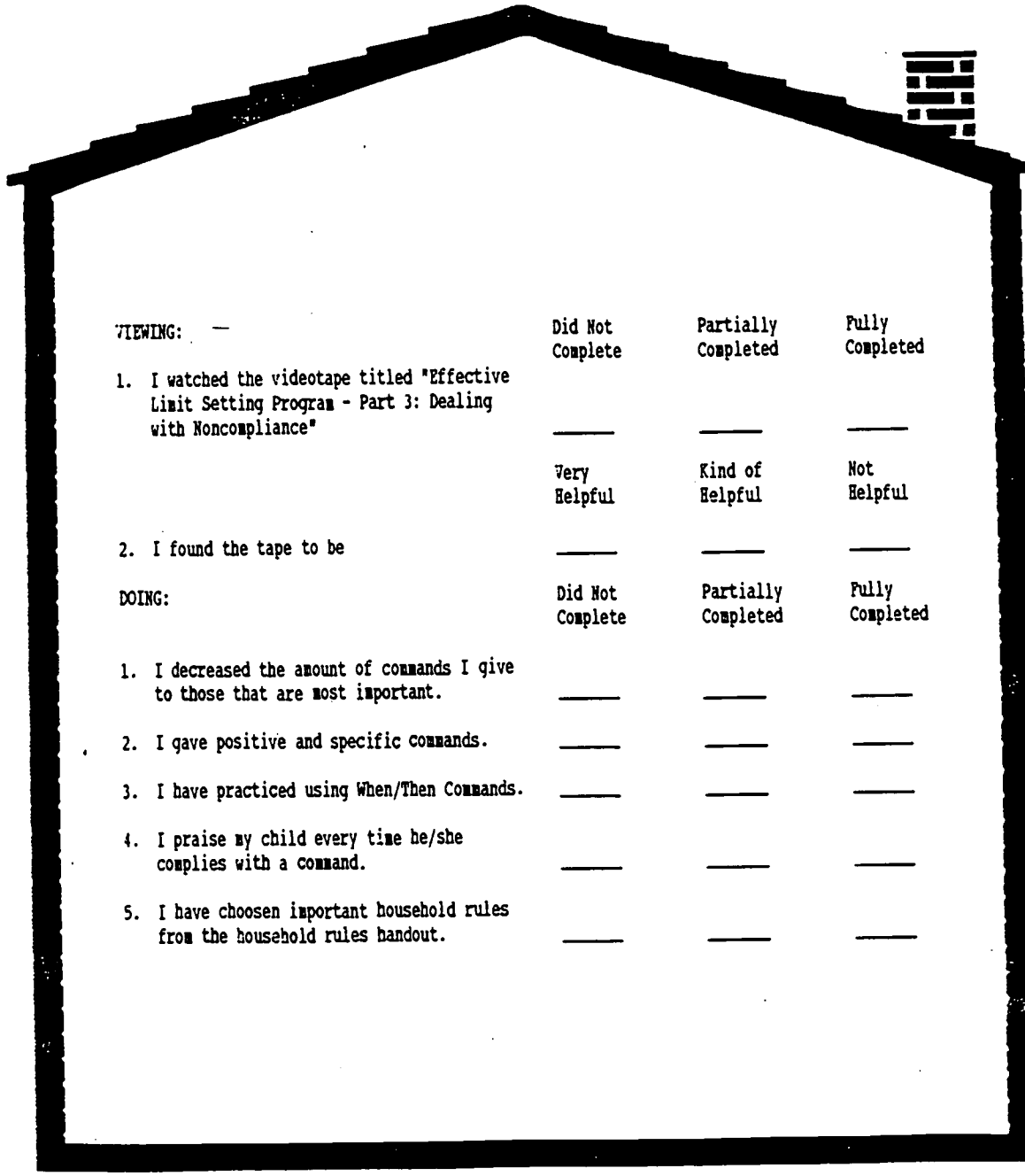
Parent's Name Date

BEST COPY AVAILABLE

Session Seven: Effective Limit Setting

"Dealing with Noncompliance"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING: —	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Effective Limit Setting Program - Part 3: Dealing with Noncompliance"	_____	_____	_____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	_____	_____	_____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I decreased the amount of commands I give to those that are most important.	_____	_____	_____
2. I gave positive and specific commands.	_____	_____	_____
3. I have practiced using When/Then Commands.	_____	_____	_____
4. I praise my child every time he/she complies with a command.	_____	_____	_____
5. I have choosen important household rules from the household rules handout.	_____	_____	_____

Parent's Name _____ Date _____

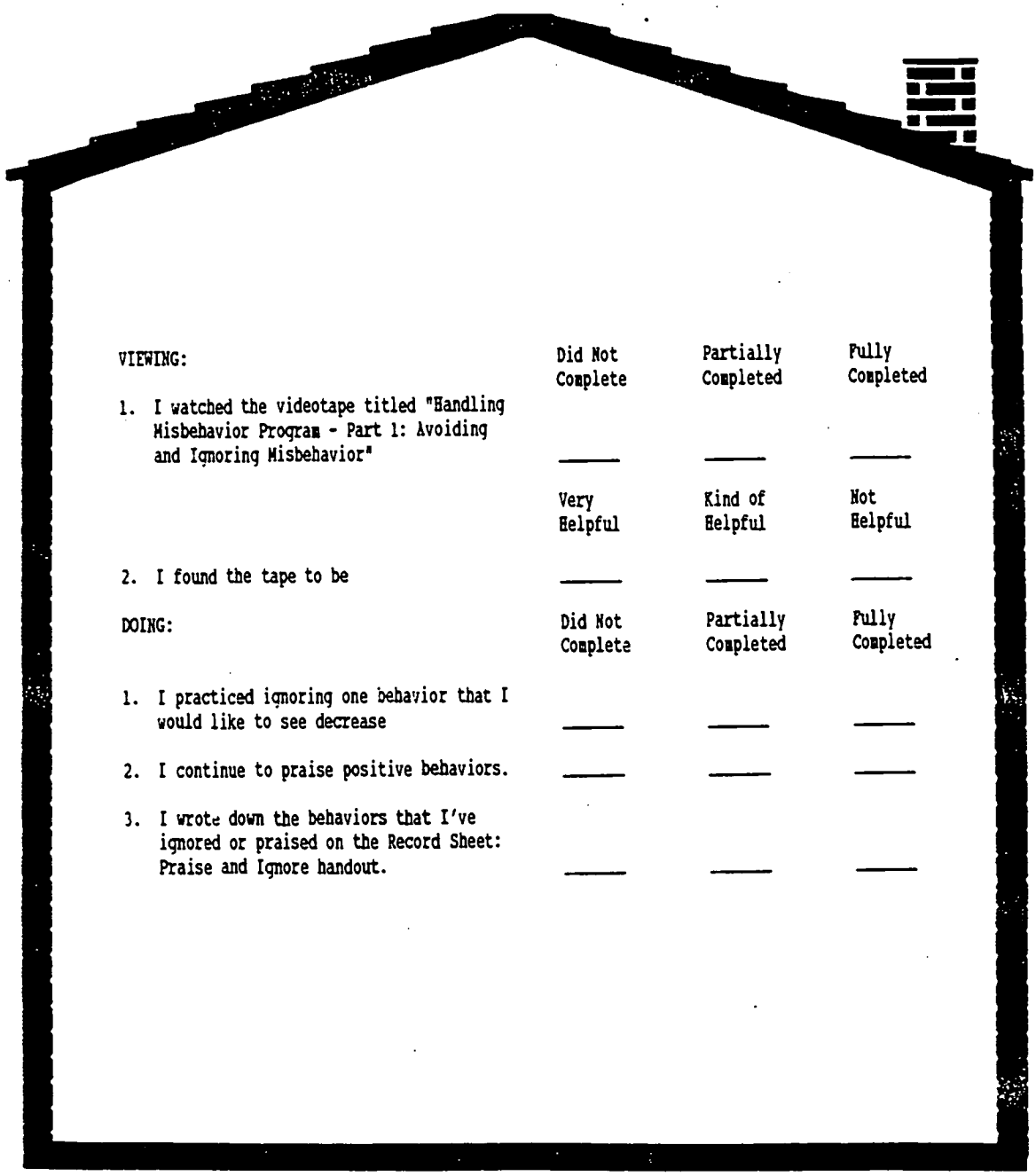
PTIP 94-95

BEST COPY AVAILABLE

Session Eight: How to Decrease Your Child's Inappropriate Behaviors

"Ignoring, Consequences, and Problem-Solving"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Handling Misbehavior Program - Part 1: Avoiding and Ignoring Misbehavior"	_____	_____	_____
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be	_____	_____	_____
DOING:	Did Not Complete	Partially Completed	Fully Completed
1. I practiced ignoring one behavior that I would like to see decrease	_____	_____	_____
2. I continue to praise positive behaviors.	_____	_____	_____
3. I wrote down the behaviors that I've ignored or praised on the Record Sheet: Praise and Ignore handout.	_____	_____	_____

_____ _____ PTIP 94-95

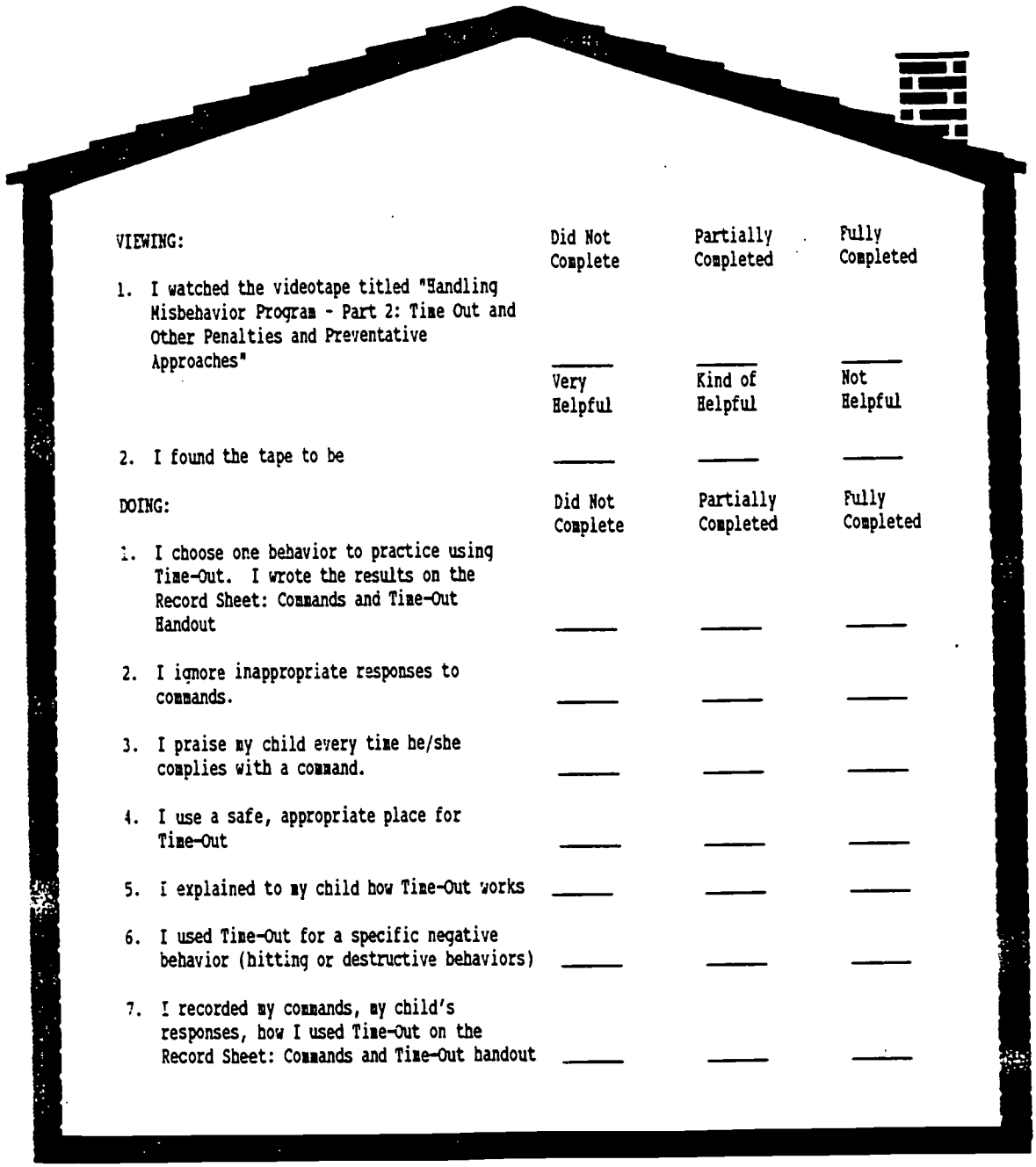
Parent's Name Date

BEST COPY AVAILABLE

Session Nine: How to Follow-Through with Limits and Rules

"Discipline Strategies for Child Disobedience and Hitting or Destructive Behaviors"

Instructions: Please indicate the extent to which you did each of the following activities during the past week.



VIEWING:	Did Not Complete	Partially Completed	Fully Completed
1. I watched the videotape titled "Handling Misbehavior Program - Part 2: Time Out and Other Penalties and Preventative Approaches"			
	Very Helpful	Kind of Helpful	Not Helpful
2. I found the tape to be			
DOING:	**Did Not Complete**	**Partially Completed**	**Fully Completed**
1. I choose one behavior to practice using Time-Out. I wrote the results on the Record Sheet: Commands and Time-Out Handout			
2. I ignore inappropriate responses to commands.			
3. I praise my child every time he/she complies with a command.			
4. I use a safe, appropriate place for Time-Out			
5. I explained to my child how Time-Out works			
6. I used Time-Out for a specific negative behavior (hitting or destructive behaviors)			
7. I recorded my commands, my child's responses, how I used Time-Out on the Record Sheet: Commands and Time-Out handout			

Parent's Name _____ Date _____

PTIP 94-95

BEST COPY AVAILABLE

Appendix I

Responding to Children's Behavior Checklist

BEST COPY AVAILABLE

Responding to Children's Behavior*

(P-TIP, 1994)

I. The following are a list of things that parents and teachers have told us they do when children misbehave. I'd like you to rate each of these actions in terms of how often you used them during the past week.

When your child **behaved inappropriately** how often did you....

Number of times in the past week:	(0) Never	(1-2) Rarely	(3-4) Sometimes	(>5) Frequently
1. Raise your voice or scold him/her?	O	O	O	O
2. Have him/her correct or make up for the problem?	O	O	O	O
3. Threaten punishment, if he/she did not stop his/her misbehavior after a warning ?	O	O	O	O
4. Restrict his/her privileges?	O	O	O	O
5. Ignore him/her, allow natural consequences to happen?	O	O	O	O
6. Follow through with stated consequences ?	O	O	O	O
7. Spank or slap him/her?	O	O	O	O
8. Give him/her a bad mark on a point chart?	O	O	O	O
9. Administer Time-Out (sent him/her to a place for a specified period of time)?	O	O	O	O
10. Tell him/her to stop misbehaving?	O	O	O	O
11. Get his/her attention and redirect him/her to a different activity?	O	O	O	O

II. The following are a list of things that parents and teachers have told us they do when children behave appropriately. I'd like you to rate each of these actions in terms of how often you used them during the past week.

When your child **behaved appropriately** how often did you....

Number of times in the past week:	(0) Never	(1-2) Rarely	(3-4) Sometimes	(>5) Frequently
1. Verbally praise him/her?	O	O	O	O
2. Provide him/her with an unexpected reward?	O	O	O	O
3. Give him/her a hug or kiss?	O	O	O	O
4. Put a good mark on a point chart?	O	O	O	O
5. Give him/her an expected reward?	O	O	O	O
6. Give him/her a special privilege?	O	O	O	O

*Adapted from materials developed by the Oregon Social Learning Center and Carloyn Webster-Stratton.

160

Appendix J

Treatment Evaluation Questionnaire - Parent Form

PARENT-TEACHER INTERVENTION PROJECT

You have just completed an intervention program identified for the Parent-Teacher Intervention Project (PTIP). Please evaluate the intervention by circling the number which best describes <u>your</u> agreement or disagreement with each statement. Please answer each question.

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1.	This was an acceptable intervention for my child's problem behavior.	1	2	3	4	5	6
2.	Most parents would find this intervention appropriate for behavior problems in addition to the one described.	1	2	3	4	5	6
3.	The intervention was effective in changing my child's problem behavior.	1	2	3	4	5	6
4.	I would suggest the use of this intervention to other parents.	1	2	3	4	5	6
5.	My child's behavior problem was severe enough to warrant use of this intervention.	1	2	3	4	5	6
6.	Most parents would find this intervention suitable for the behavior problem described.	1	2	3	4	5	6
7.	The intervention did <u>not</u> result in negative side-effects for my child.	1	2	3	4	5	6
8.	The intervention would be appropriate for a variety of children.	1	2	3	4	5	6
9.	The intervention was a fair way to handle my child's problem behavior.	1	2	3	4	5	6
10.	I liked the procedure used in the intervention.	1	2	3	4	5	6
11.	The intervention was a good way to handle my child's behavior problem.	1	2	3	4	5	6
12.	Overall, the intervention was beneficial for my child.	1	2	3	4	5	6
13.	The intervention quickly improved my child's behavior.	1	2	3	4	5	6
14.	The intervention produced a lasting improvement in my child's behavior.	1	2	3	4	5	6

162

BEST COPY AVAILABLE

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
15.	The intervention improved my child's behavior to the point that it would not noticeably deviate from other children's behavior.	1	2	3	4	5	6
16.	Soon after using the intervention, I noticed a positive change in my child's problem behavior.	1	2	3	4	5	6
17.	My child's behavior remained at an improved level even after the intervention was discontinued.	1	2	3	4	5	6
18.	Using the intervention not only improved my child's behavior in the home, but also in other settings (e.g., other homes).	1	2	3	4	5	6
19.	When comparing my child with a well-behaved peer before and after use of the intervention, my child's and peer's behavior was more alike after using the interventions.	1	2	3	4	5	6
20.	The intervention produced enough improvement in my child's behavior so the behavior no longer was a problem.	1	2	3	4	5	6
21.	Other behaviors related to the problem behavior also were improved by the intervention.	1	2	3	4	5	6

BEST COPY AVAILABLE

Appendix K

Treatment Evaluation Questionnaire - Teacher Form

PARENT-TEACHER INTERVENTION PROJECT

You have just completed an intervention program identified for the Parent-Teacher Intervention Project (PTIP). Please evaluate the intervention by circling the number which best describes <u>your</u> agreement or disagreement with each statement. Please answer each question.

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1.	This was an acceptable intervention for the child's problem behavior.	1	2	3	4	5	6
2.	Most teachers would find this intervention appropriate for behavior problems in addition to the one described.	1	2	3	4	5	6
3.	The intervention was effective in changing the child's problem behavior.	1	2	3	4	5	6
4.	I would suggest the use of this intervention to other teachers.	1	2	3	4	5	6
5.	The child's behavior problem was severe enough to warrant use of this intervention.	1	2	3	4	5	6
6.	Most teachers would find this intervention suitable for the behavior problem described.	1	2	3	4	5	6
7.	I was willing to use this intervention in the classroom setting.	1	2	3	4	5	6
8.	The intervention did <u>not</u> result in negative side-effects for the child.	1	2	3	4	5	6
9.	The intervention would be appropriate for a variety of children.	1	2	3	4	5	6
10.	The intervention is consistent with those I have used in classroom settings.	1	2	3	4	5	6
11.	The intervention was a fair way to handle the child's problem behavior.	1	2	3	4	5	6
12.	The intervention was reasonable for the behavior problem described.	1	2	3	4	5	6
13.	I liked the procedure used in the intervention.	1	2	3	4	5	6
14.	The intervention was a good way to handle this child's behavior problem.	1	2	3	4	5	6
15.	Overall, the intervention was beneficial for the child.	1	2	3	4	5	6

BEST COPY AVAILABLE

165

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
16.	The intervention quickly improved the child's behavior.	1	2	3	4	5	6
17.	The intervention produced a lasting improvement in the child's behavior.	1	2	3	4	5	6
18.	The intervention improved the child's behavior to the point that it would not noticeably deviate from other children's behavior.	1	2	3	4	5	6
19.	Soon after using the intervention, the teacher noticed a positive change in the problem behavior.	1	2	3	4	5	6
20.	The child's behavior will remain at an improved level even after the intervention was discontinued.	1	2	3	4	5	6
21.	Using the intervention not only improved the child's behavior in the classroom, but also in other settings (e.g., other classrooms).	1	2	3	4	5	6
22.	When comparing this child with a well-behaved peer before and after use of the intervention, the child's and peer's behavior was more alike after using the interventions.	1	2	3	4	5	6
23.	The intervention produced enough improvement in the child's behavior so the behavior no longer was a problem.	1	2	3	4	5	6
24.	Other behaviors related to the problem behavior also were improved by the intervention.	1	2	3	4	5	6

BEST COPY AVAILABLE

Appendix L

Parent Consultation Services Questionnaire

PARENT-TEACHER INTERVENTION PROJECT

Parent Consultation Services Questionnaire

Thank you for your participation in the Parent-Teacher Intervention Project (PTIP). Your cooperation has been greatly appreciated. The following questionnaire is part of an evaluation of the PTIP. The information obtained will help us evaluate and improve the program; therefore, it is important that you respond as honestly as possible.

Overall Program

Please circle the response that best expresses your feelings.

1. The major problem that originally prompted me to seek treatment for my child is presently

- considerably worse
- worse
- slightly worse
- the same
- slightly improved
- improved
- greatly improved

2. My child's problems that have been treated during my participation in the program are now

- considerably worse
- worse
- slightly worse
- the same
- slightly improved
- improved
- greatly improved

3. My child's problems that have not been treated during my participation are

- considerably worse
- worse
- slightly worse
- the same
- slightly improved
- improved
- greatly improved

4. My feelings now about my child's progress are that I am

- very dissatisfied
- dissatisfied
- slightly dissatisfied
- neutral
- slightly satisfied
- satisfied
- very satisfied

5. To what degree has the treatment program helped with other general personal or family concerns not directly related to your child?

- hindered much more than helped
- hindered
- hindered slightly
- neither helped nor hindered
- helped slightly
- helped
- helped very much

6. At this time, I believe that the treatment will continue to have a positive outcome.

- strongly disagree
- disagree
- somewhat disagree
- neutral
- somewhat agree
- agree
- strongly agree

7. I feel the approach to treating my child's behavior problems in the home by using this type of video-based parent program is

- very inappropriate
- inappropriate
- slightly inappropriate
- neutral
- slightly appropriate
- appropriate
- very appropriate

BEST COPY AVAILABLE

8. Would you recommend the program to a friend or a relative?

- strongly recommended
- recommended
- slightly recommended
- recommended
- slightly not recommended
- not recommended
- strongly not recommended

9. How confident are you in managing your child's current behavior problems in the home on your own?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

10. How confident are you in your ability to manage future behavior problems of your child in the home using what you learned from this program?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

11. My overall feeling about the treatment program for my child and family is

- very negative
- negative
- slightly negative
- neutral
- slightly positive
- positive
- very positive

Teaching Format

We would like to know how difficult each of the following types of teaching has been for you to follow. In addition, we would like to get your ideas on how useful each of the instructional strategies were for you. Please circle the response that most closely describes your opinion.

1. Instructions from the Consultant

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

2. Treatment methods or skills demonstrated in the videos

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

3. Use of skills in the home with your child

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

BEST COPY AVAILABLE

4. The home assignments you were asked to complete

Difficulty:

1 - extremely easy	4 - neutral	5 - somewhat difficult
2 - easy		6 - difficult
3 - somewhat easy		7 - extremely difficult

Usefulness:

1 - extremely not useful	4 - neutral	5 - somewhat useful
2 - not useful		6 - useful
3 - somewhat not useful		7 - extremely useful

5. The written materials (manual) you were asked to read

Difficulty:

1 - extremely easy	4 - neutral	5 - somewhat difficult
2 - easy		6 - difficult
3 - somewhat easy		7 - extremely difficult

Usefulness:

1 - extremely not useful	4 - neutral	5 - somewhat useful
2 - not useful		6 - useful
3 - somewhat not useful		7 - extremely useful

Parent Opinion

How could the program be improved to help you more?

BEST COPY AVAILABLE

Parent Benefits

For each of the following statements, circle the number which most accurately reflects the benefits you have received as a result of working with the consultant.

0 = Don't Know or Not Applicable
1 = Strongly Disagree
2 = Somewhat Disagree
3 = Disagree
4 = Neutral
5 = Agree
6 = Somewhat Agree
7 = Strongly Agree

1. I am able to see the problem situation in great depth.

   0 1 2 3 4 5 6 7

2. I am able to see other ways of dealing with a problem that I hadn't thought of before.

   0 1 2 3 4 5 6 7

3. I find myself trying out some of my own ideas.

   0 1 2 3 4 5 6 7

4. I feel encouraged to make my own decisions regarding the management of my child's problems.

   0 1 2 3 4 5 6 7

5. I am able to interact more effectively with my child.

   0 1 2 3 4 5 6 7

6. Did you implement any of the strategies you learned during consultation and training sessions?

   ___No ___Yes (Specify which ones: _____

   _____)

   (a) If yes, how successful were they?

   Unsuccessful 1 2 3 4 5 6 7 Successful

   (b) If no, why not? _____

   _____

7. How confident are you in your ability to solve similar problems of your child's in the future?

   Not at all 1 2 3 4 5 6 7 Very Confident

BEST COPY AVAILABLE

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

The Consultant

For each of the following statements, please circle the number which most accurately reflects your perception of the consultant you worked with during the consultation and training sessions. Use the same 0-7 scale above.

1. Easy to work with

   0 1 2 3 4 5 6 7

2. Knowledgeable about the behavior of individual children

   0 1 2 3 4 5 6 7

3. Established a good relationship with parents

   0 1 2 3 4 5 6 7

4. A good listener

   0 1 2 3 4 5 6 7

5. Offered useful information

   0 1 2 3 4 5 6 7

6. Seemed flexible in his/her ideas

   0 1 2 3 4 5 6 7

7. Helped identify useful resources

   0 1 2 3 4 5 6 7

8. Viewed role as a facilitator rather than an expert

   0 1 2 3 4 5 6 7

BEST COPY AVAILABLE

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

9. Respected values which were different

0 1 2 3 4 5 6 7

10. Understood important aspects of problems brought up

0 1 2 3 4 5 6 7

11. Worked well with teachers

0 1 2 3 4 5 6 7

12. Provided moral support

0 1 2 3 4 5 6 7

13. Appeared interested in my concerns

0 1 2 3 4 5 6 7

14. Offered a valuable service

0 1 2 3 4 5 6 7

Thank you!

BEST COPY AVAILABLE

Appendix M

Teacher Consultation Services Questionnaire

PARENT-TEACHER INTERVENTION PROJECT

Teacher Consultation Services Questionnaire

Thank you for your participation in the Parent-Teacher Intervention Project (PTIP). Your cooperation has been greatly appreciated. The following questionnaire is part of an evaluation of the PTIP. The information obtained will help us evaluate and improve the program; therefore, it is important that you respond as honestly as possible.

Overall Program

Please circle the response that best expresses your feelings.

1. The major problem that originally prompted me to refer the child is presently

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

2. The child's problems that have been treated during my participation in the program are now

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

3. The child's problems that have not been treated during my participation are

   - considerably worse
   - worse
   - slightly worse
   - the same
   - slightly improved
   - improved
   - greatly improved

4. My feelings now about the child's progress are that I am

   - very dissatisfied
   - dissatisfied
   - slightly dissatisfied
   - neutral
   - slightly satisfied
   - satisfied
   - very satisfied

5. To what degree has the treatment program helped with other general personal or family concerns not directly related to the child?

   - hindered much more than helped
   - hindered
   - hindered slightly
   - neither helped nor hindered
   - helped slightly
   - helped
   - helped very much

6. I feel the approach to treating the child's behavior problems in the school by using this type of program is

   - very inappropriate
   - inappropriate
   - slightly inappropriate
   - neutral
   - slightly appropriate
   - appropriate
   - very appropriate

BEST COPY AVAILABLE

7. Would you recommend the program to a colleague?

- strongly recommended
- recommended
- slightly recommended
- recommended
- slightly not recommended
- not recommended
- strongly not recommended

8. How confident are you in managing <u>current</u> behavior problems in the classroom on your own?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

9. How confident are you in your ability to manage <u>future</u> behavior problems in the classroom using what you learned from this program?

- very confident
- confident
- slightly confident
- neutral
- somewhat unconfident
- unconfident
- very unconfident

10. My overall feeling about the program for the child is

- very negative
- negative
- slightly negative
- neutral
- slightly positive
- positive
- very positive

<u>Teaching Format</u>

We would like to know how <u>difficult</u> each of the following types of teaching has been for you to follow. In addition, we would like to get your ideas on how <u>useful</u> each of the instructional strategies were for you. Please circle the response that most closely describes your opinion.

1. Instructions from the Consultant

<u>Difficulty</u>:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

<u>Usefulness</u>:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

2. Treatment methods or skills demonstrated in the videos

<u>Difficulty</u>:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

<u>Usefulness</u>:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

BEST COPY AVAILABLE

ERIC

3. Use of skills in the classroom with the child

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

4. Task assignments you were asked to complete

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

5. The written materials (manual) you were asked to read

Difficulty:
1 - extremely easy
2 - easy
3 - somewhat easy
4 - neutral
5 - somewhat difficult
6 - difficult
7 - extremely difficult

Usefulness:
1 - extremely not useful
2 - not useful
3 - somewhat not useful
4 - neutral
5 - somewhat useful
6 - useful
7 - extremely useful

Teacher Opinion

How could the program be improved to help you more?

BEST COPY AVAILABLE

Teacher Benefits

For each of the following statements, circle the number which most accurately reflects the benefits you have received as a result of working with the consultant.

---

0 = Don't Know or Not Applicable
1 = Strongly Disagree
2 = Somewhat Disagree
3 = Disagree
4 = Neutral
5 = Agree
6 = Somewhat Agree
7 = Strongly Agree

---

1. I am able to see complexities of the problem situation in great depth and breadth.

   0 1 2 3 4 5 6 7

2. I am able to see alternative ways of dealing with a problem that I hadn't thought of before.

   0 1 2 3 4 5 6 7

3. I find myself trying out some of my own ideas.

   0 1 2 3 4 5 6 7

4. I feel encouraged to make my own decisions regarding the management of the child's problems.

   0 1 2 3 4 5 6 7

5. I am able to interact more effectively with the child.

   0 1 2 3 4 5 6 7

6. Did you implement any of the strategies you learned during consultation and training sessions?

   ___No ___Yes (Specify which ones: _____

   _____)

   (a) If yes, how successful were they?

   Unsuccessful 1 2 3 4 5 6 7 Successful

   (b) If no, why not? _____

   _____

7. How confident are you in your ability to solve similar problems in the future?

   Not at all 1 2 3 4 5 6 7 Very Confident

BEST COPY AVAILABLE

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

The Consultant

For each of the following statements, please circle the number which most accurately reflects your perception of the consultant you worked with during the consultation and training sessions. Use the same 0-7 scale above.

1. Easy to work with

   0 1 2 3 4 5 6 7

2. Knowledgeable about the behavior of individual children

   0 1 2 3 4 5 6 7

3. Established a good relationship with teachers

   0 1 2 3 4 5 6 7

4. A good listener

   0 1 2 3 4 5 6 7

5. Offered useful information

   0 1 2 3 4 5 6 7

6. Seemed flexible in his/her ideas

   0 1 2 3 4 5 6 7

7. Helped identify useful resources

   0 1 2 3 4 5 6 7

8. Viewed role as a facilitator rather than an expert

   0 1 2 3 4 5 6 7

BEST COPY AVAILABLE

0 = Don't Know or Not Applicable	4 = Neutral
1 = Strongly Disagree	5 = Agree
2 = Somewhat Disagree	6 = Somewhat Agree
3 = Disagree	7 = Strongly Agree

The Consultant

For each of the following statements, please circle the number which most accurately reflects your perception of the consultant you worked with during the consultation and training sessions. Use the same 0-7 scale above.

1. Easy to work with

   0 1 2 3 4 5 6 7

2. Knowledgeable about the behavior of individual children

   0 1 2 3 4 5 6 7

3. Established a good relationship with teachers

   0 1 2 3 4 5 6 7

4. A good listener

   0 1 2 3 4 5 6 7

5. Offered useful information

   0 1 2 3 4 5 6 7

6. Seemed flexible in his/her ideas

   0 1 2 3 4 5 6 7

7. Helped identify useful resources

   0 1 2 3 4 5 6 7

8. Viewed role as a facilitator rather than an expert

   0 1 2 3 4 5 6 7

BEST COPY AVAILABLE

Appendix N

Conjoint Behavioral Consultation Interviews

BEST COPY AVAILABLE

Conjoint Behavioral Consultation:
Problem Identification Interview (PII)

Objectives and Definitions

PII Goals:

* Provide an overview of the project.
* Establish a working relationship between parents and teacher, and between the consultant and consultees.
* Confirm teacher and parent permission for project participation.
* Collect information about formal composition, receptivity, involvement, home problems, special needs, etc.
* Establish primary language of parent.
* Present the results of the screening.
* Define the problem(s) in behavioral terms (i.e. provide an operational definition).
* Provide a tentative identification of behavior in terms of antecedent, situation, and consequent conditions across settings.
* Provide a tentative strength of the behavior across settings (i.e. how often or severe).
* Discuss and reach agreement on a goal for behavior change across settings.
* Establish a procedure for collection of baseline data across settings in terms of sampling plan, what, who, and how the behavior is to be recorded.

Interview Objectives:

OPENING SALUTATION

PROJECT SUMMARY: Summarize what will be covered during the meeting.

GENERAL STATEMENT: General statement to begin discussion related to referral concerns. Specifically discuss the general results of the screening process.

Examples: What seems to be the problem?
What is it that you are concerned about?

Establish Primary Language of Parent: Ask, "What is the primary language of the home?"

182

BEHAVIOR SPECIFICATION: Elicit behavioral descriptions of client functioning. Focus on specific behaviors. Provide as many examples of the problem as possible. Prioritize the problems from the most to the least severe (problems across settings should be prioritized).

a. Behavioral description:

What does Jamie do when he's angry?
Tell me what you mean when you say, " he gets upset with himself easily."
Give me some examples of what you mean by, "self-abusive behaviors."

b. Elicit examples:

What are some more examples of Jamie's "self-abusive" behaviors at home/at school?

c. Prioritize behavior:

We've discussed several behaviors, such as head-slapping, kicking objects, ripping up papers, and screaming.
Which of these is most problematic across settings?
Do you both agree?

BEHAVIOR SETTING: A precise description of the settings in which the problem behavior occurs.

a. General setting description:

Where is Jamie usually when he hits himself?
Give me some examples of where Jamie does this at school.
Where does the head-slapping occur at home?

b. Elicit examples:

What are some more examples of where this occurs?

c. Prioritize settings:

Which of the settings at school is most problematic?
Which of the settings at home is most problematic?

IDENTIFY ANTECEDENTS: Events which precede the child's behavior. These events can immediately precede the behavior, or they may be removed in time (e.g. events at home in the morning that impact the child's behavior at school, etc.).

Examples: What typically happens at home/at school before Jamie starts to hit himself?

What things do you notice before he starts that might be contributing to its occurrence?

What is a typical morning like before Jamie goes to school?

SEQUENTIAL CONDITIONS ANALYSIS: Situational events or environmental conditions occurring when the behavior occurs. A pattern or trend of antecedent/consequent conditions across a series of occasions (e.g. time of day, day of week).

Examples: What else is typically happening in the classroom/playground/home when Jamie is observed hitting himself?

What patterns do you notice in Jamie's head slapping behavior?

What time of day or day of week seems to be most problematic at home/at school?

IDENTIFY CONSEQUENT CONDITIONS: Events which occur immediately following the behavior. These can be reactions of parents, teachers, or peers, and they can occur immediately following the behavior or at a later point in time (e.g. at home after school).

Examples: What typically happens after Jamie hits himself at home/at school?
What types of things do you notice at home/at school after that might be maintaining its occurrence?

How are school-related problems handled at home?

BEHAVIOR STRENGTH: The level or incidence of the behavior: how often (frequency) or how long (duration) the behavior occurs. The question format will depend on the specific behavior and focus on consultation.

Examples: How often does Jamie hit himself at home/at school?
How long does it last?
On a scale of 0 - 10, how severe is the behavior at home/at school?

BEST COPY AVAILABLE

GOAL OF CONSULTATION: Appropriate or acceptable level of the behavior.

Examples: What would be an acceptable level of head-slapping at home/at school?

Is any head-slapping OK?

What would you like to see for Jamie?

Is there general agreement on our goal for Jamie across home and school?

CHILD'S STRENGTHS/ASSETS: Strengths, abilities, or other positive features of the child.

Examples: What are some of the things that Jamie is good at?

What are some of Jamie's strengths?

BEST COPY AVAILABLE

EXISTING PROCEDURES: Procedures or rules in force that are external to the child and to the behavior.

Examples: What are some programs or procedures that are currently operating in the classroom?

How are problems currently dealt with when they occur at home/at school?

PROVIDE A RATIONALE FOR DATA COLLECTION: A purpose or rationale for data collection is provided. At this time also note that observers will also be used to gather data in the home and classroom setting.

Examples: It would be very helpful to watch Jamie for a week or so and monitor how often he hits himself in the head. This will help us key in on some important facts that we may have missed, and also help us document the progress that Jamie makes.

DISCUSS DATA COLLECTION PROCEDURES: Specify the target responses to record, including the kind of measure, what is to be recorded, and how to record. Consistent data collection procedures across should be encouraged. Specific details of data recording should be emphasized. A written plan and format for parents and teachers is often helpful.

Examples: What would be a simple way for you to keep track of Jamie's head-slapping at home/at school?

DATE TO BEGIN DATA COLLECTION: Procedural details regarding when to begin collection data.

Examples: When can you begin to collect data at home/at school?

NEXT APPOINTMENT: Establish meeting time for PAI. Note that PAI will occur at different times for teacher and parent.

Examples: When can we all get together again to discuss the data and determine where to go from here?

PII

Conjoint Behavioral Consultation: Problem Identification Interview (PII)

Child's Name:_____ Date:_____

Parent's Name:_____ Age: _____

Teacher's Name:_____ Grade:_____

School: _____

Consultant's Name:_____

PII Goals:

* Provide an overview of the project.
* Establish a working relationship between parents and teacher, and between the consultant and consultees.
* Confirm teacher and parent permission for project participation.
* Collect information about formal composition, receptivity, involvement, home problems, special needs, etc.
* Establish primary language of parent.
* Present the results of the screening.
* Define the problem(s) in behavioral terms (i.e. provide an operational definition).
* Provide a tentative identification of behavior in terms of antecedent, situation, and consequent conditions across settings.
* Provide a tentative strength of the behavior across settings (i.e. how often or severe).
* Discuss and reach agreement on a goal for behavior change across settings.
* Establish a procedure for collection of baseline data across settings in terms of sampling plan, what, who, and how the behavior is to be recorded.

Conjoint Behavioral Consultation:
Problem Identification Interview (PII)

The consultant should question and/or comment on all of the following:

OPENING SALUTATION

ESTABLISH PRIMARY LANGUAGE OF PARENTS

SUMMARIZE SCREENING RESULTS

GENERAL STATEMENT

What seems to be the problem?
What is it that you are concerned about?

HOME	SCHOOL

BEHAVIOR SPECIFICATION

a. Tell me what you mean by...
Give me some examples of what you mean by...
What does _____ do?

HOME	SCHOOL

b. What are some more examples?

HOME	SCHOOL

c. We've discussed several behaviors, such as...
Which of is most problematic across settings?
Do you both agree?

HOME	SCHOOL

** SUMMARIZE TARGET BEHAVIOR IN PRECISE, OBSERVABLE TERMS **

BEHAVIOR SETTING

a. Where does _____ display this behavior?

Give me some examples of where this occurs.

HOME	SCHOOL

b. What are some more examples of where this occurs?

HOME	SCHOOL

c. Which of the settings at school is most problematic?
Which of the settings at home is most problematic?

HOME	SCHOOL

IDENTIFY ANTECEDENTS

What usually happens at home/at school before the behavior occurs? What things do you notice before the behavior that might be contributing to its occurrence? What is a typical morning like before _____ goes to school?

HOME	SCHOOL

SEQUENTIAL CONDITIONS ANALYSIS

What else is typically happening in the classroom, on the playground, or at home when the behavior occurs?

What patterns do you notice in _____'s behavior?

What time of the day or week seems to be the most problematic at home/at school?

HOME	SCHOOL

IDENTIFY CONSEQUENT CONDITIONS

What typically happens after the behavior occurs at home/at school?

What types of things do you notice at home/at school after the behavior occurs that might be maintaining its occurrence?

How are school-related problems handled at home?

HOME	SCHOOL

** SUMMARIZE AND VALIDATE CONDITIONS SURROUNDING THE BEHAVIOR **

BEHAVIOR STRENGTH

How often does this behavior occur at home/at school?
How long does it last?
On a scale of 0 - 10, how severe is the behavior at home/at school?

HOME	SCHOOL

** SUMMARIZE AND VALIDATE THE SPECIFIC BEHAVIOR AND ITS STRENGTH **

GOAL OF CONSULTATION

What would be an acceptable level of this behavior at home/at school?
What would _____ have to do to get along OK?
Is there a general agreement of our goal across home and school?

HOME	SCHOOL

CHILD'S STRENGTHS/ASSETS

What are some of the things that _____ is good at?
What are some of _____'s strengths?

HOME	SCHOOL

EXISTING PROCEDURES

What are some programs or procedures that are currently operating in the classroom?

How are problems currently dealt with when they occur at home/at school?

HOME	SCHOOL

** SUMMARIZE AND VALIDATE BEHAVIOR, STRENGTH, GOAL, ETC. **

PROVIDE A RATIONALE FOR DATA COLLECTION

It would be very helpful to watch _____ for a week or so and monitor the occurrence of the behavior. This will help us key in on some important facts that we may have missed, and also help us document the progress that is made towards our goal.

DISCUSS DATA COLLECTION PROCEDURES

What would be a simple way for you to keep track of the behavior at home/at school?

HOME	SCHOOL

** SUMMARIZE/VALIDATE DATA COLLECTION PROCEDURES **

DATE TO BEGIN DATA COLLECTION

When can you begin to collect data at home/at school?

HOME	SCHOOL

NEXT APPOINTMENT

When can we all get together again to discuss the data and determine where to go from here?

CLOSING SALUTATION

Conjoint Behavioral Consultation:
Problem Analysis Interview (PAI)

Objectives and Definitions

PAI Goals :

* Secure teacher and parent permission for treatment program
* Evaluate and obtain agreement on the sufficiency and adequacy of baseline data across settings.
* Conduct a tentative functional analysis of the behavior across settings (i.e. discuss antecedent, consequent, and sequential conditions).
* Identify setting events (events that are functionally related, but temporally or contextually distal to the target behavior), ecological conditions, and other cross-setting variables that may impact the target behaviors.
* Implement an intervention plan including specification of conditions to be changed and the practical guidelines regarding treatment implementation in the Treatment Manual.
* Reaffirm record-keeping procedures.

Interview Objective:

OPENING SALUTATION

GENERAL STATEMENT RE: DATA AND PROBLEM

Example: Were you able to keep a record of ... ?

BEHAVIOR STRENGTH: Question or statement regarding behaviors, specific to the baseline data collected.

Example: According to the data, it looks like Jamie hit himself in the head at least 4 times at home and 5 times at school each day.

ANTECEDENT CONDITIONS: Information regarding events which precede the child's behavior. These events may have immediately preceded the behavior, or they may have been removed in time (e.g. events at home in the morning that impact the child's behaviors at school, etc.). Refer to baseline data in this discussion.

Examples: What did you notice before Jamie began to hit himself at home/at school?

What things may have led up to its occurrence?

CONSEQUENT CONDITIONS: Events which occurred following the behavior. These can be reactions of parents, teachers, or peers, and they can occur immediately following the behavior or at a later point in time (e.g. at home after school). Refer to baseline data in this discussion.

Examples: What typically happened after Jamie hit himself at home/at school?

What types of things did you notice afterwards that may have maintained its occurrence?

SEQUENTIAL CONDITIONS: Situational events or environmental conditions occurring when the behavior occurs. A pattern or trend of antecedent/ consequent conditions across a series of occasions (e.g. time of day, day of week).

Examples: What else was happening in the classroom/ playground/home when you observed Jamie hitting himself?

What time of day, or day of week seemed most problematic?

What patterns did you notice in Jamie's behavior at home/at school?

INTERPRETATION OF BEHAVIOR: Parents' and teachers' perceptions regarding the purpose or function of the behavior. Consultant may also suggest hypotheses regarding the behavior if other explanations are plausible.

Examples: Why do you think Jamie hits himself?

It sounds like it might also be related to a very low frustration tolerance level.

ESTABLISHING A PLAN: Plan strategies are established with the intention of implementing the intervention across settings. The tentative goal stated in the PII, the interpretation of the behavior, and the child's strengths should be considered in the plan.

Examples: It seems that we need to try something different.

What can be done at both home and school to stop Jamie from hitting himself and to teach him alternative, more appropriate ways to cope with frustration?

CONTINUE DATA RECORDING PROCEDURES: Data recording procedures to be used in treatment implementation. Should be identical to or consistent with baseline data collection procedures.

Examples: It would be very helpful if we could continue to collect data on the number of times that Jamie hits himself each day at home and school.

Can we continue the same recording procedures as before?

NEXT APPOINTMENT: Establish a meeting time for the TEI.

CLOSING SALUTATION

PAI

Conjoint Behavioral Consultation:
Problem Analysis Interview (PAI)

Child's Name:_____ Date:_____

Parent's Name:_____ Age:_____

Teacher's Name:_____ Grade:_____

School:_____

Consultant's Name: _____

PAI Goals:

* Secure teacher and parent permission for treatment program
* Evaluate and obtain agreement on the sufficiency and adequacy of baseline data across settings.
* Conduct a tentative functional analysis of the behavior across settings (i.e. discuss antecedent, consequent, and sequential conditions).
* Identify setting events (events that are functionally related, but temporally or contextually distal to the target behavior), ecological conditions, and other cross-setting variables that may impact the target behaviors.
* Implement an intervention plan including specification of conditions to be changed and the practical guidelines regarding treatment implementation in the Treatment Manual.
* Reaffirm record-keeping procedures.

Conjoint Behavioral Consultation:
Problem Analysis Interview (PAI)

The consultant should question and/or comment on the following:

OPENING SALUTATION

SECURE TEACHER AND PARENT PERMISSION FOR TREATMENT

GENERAL STATEMENT RE: DATA AND PROBLEM

Were you able to keep a record of .....?

HOME	SCHOOL

BEHAVIOR STRENGTH

According to the data, it looks like the behavior occurred at home/at school.

HOME	SCHOOL

ANTECEDENT CONDITIONS

What did you notice before the problem occurred at home/at school? What things may have led up to its occurrence?
What happened before school on these days?

** Refer to baseline data!

HOME	SCHOOL

CONSEQUENT CONDITIONS

What typically happened after the occurrence of the behavior at home/at school?

What types of things did you notice afterwards that may have maintained its occurrence?

What happened after school on these days?

** Refer to baseline data!

HOME	SCHOOL

SEQUENTIAL CONDITIONS

What else was happening in the classroom, on the playground, or at home when the behavior occurred?

What time of day, or what day of the week seemed most problematic at home/at school?

What patterns did you notice in _____'s behavior at home/at school?

HOME	SCHOOL

** SUMMARIZE AND VALIDATE BEHAVIOR AND STRENGTH CONDITIONS **

INTERPRETATION OF BEHAVIOR

Why do you think _____ does this?

It sounds like the behavior might also be related to...?

HOME	SCHOOL

ESTABLISHING A TREATMENT PLAN

We have prepared some written materials that will help you implement a program for _____.

We also have recorded the material on a tape cassette so that you can also listen to the material reviewed in the manual.

HOME	SCHOOL

** SUMMARIZE AND VALIDATE PLAN ACROSS SETTINGS **

CONTINUE DATA RECORDING PROCEDURES

It would be very helpful if we could continue to collect data on _____'s behavior.

Can we continue the same recording procedure as before?

HOME	SCHOOL

NEXT APPOINTMENT

When can all get together again to discuss the data and determine where to go from here?

CLOSING SALUTATION

Conjoint Behavioral Consultation
Treatment Evaluation Interview (TEI)

Objectives and Definitions

TEI Goals:

* Determine if the goals of consultation have been obtained across settings.
* Evaluate the effectiveness of the treatment plan across settings.
* Discuss strategies and tactics regarding the continuation, modification, or termination of the treatment plan.
* Schedule additional interviews if necessary, or terminate consultation.

Interview Objectives:

OPENING SALUTATION

EVALUATE GENERAL PROCEDURES AND OUTCOME: Question or statement regarding general procedures and outcome.

Example: How did things go with the plan?

QUESTIONS ABOUT GOAL ATTAINMENT: Determine specifically if the goals of consultation have been attained. Refer to treatment data collected, and the goal statement specifies in the PII.

Example: Has our goal of 1 "head slap" per day been met at home/at school?

If goals have been attained:

EVALUATE PLAN EFFECTIVENESS:
Determine the effectiveness of the plan for the specific child. Was the specific plan effective in producing behavior change, or are there other competing explanations? What is the internal validity of the plan?

Example: Do you think that the behavior program was responsible for Jamie's decrease in head-slapping?

EVALUATE EXTERNAL VALIDITY OF PLAN:
Determine the potential effectiveness of the plan for another setting where the child has a similar problem. This tactic may also increase the potential for consultees to generalize the plan to other clients.

Example: Do you think this plan would work with another child with similar difficulties?

CONDUCT POST-IMPLEMENTATION PLANNING:
Decision is made regarding the advisability of leaving the plan in effect, removing the plan, or constructing a new plan. Selecting a post-treatment alternative to implement across settings may occur.

Example: Should we leave the plan in effect for a while longer?

PROCEDURES FOR GENERALIZATION/MAINTENANCE:
Procedures to encourage continued progress are discussed. The goal is to encourage generalization to other behaviors, persons, or situations, or to maintain behavior over a long period of time. If the goals of consultation are not met, this question may not be non-applicable.

Example: How can we encourage _____ to display these behavior changes in other problem settings?

What procedures should we use to make sure that the behavior change continues over time?

If goals have not been attained:

QUESTIONS RE: PLAN MODIFICATION:
Establish new plan strategies to increase plan effectiveness across settings Consultant may suggest a change or question the need for change. If plan is successful and goals are met, this question may be nonapplicable.

Examples: How can we modify the procedures so that the plan is more effective?

FOLLOW-UP ASSESSMENT: Discussion regarding follow-up recording procedures to monitor the behavior over time and over settings.

Example: How can we monitor Jamie's progress to ensure that these positive changes continue?

QUESTIONS RE: NEED FOR FUTURE INTERVIEWS

Example: When can we meet again to discuss the effectiveness of our modified plan?

Would you like to meet again to check on _____'s progress?

TERMINATION OF CONSULTATION (if goals have been met)

CLOSING SALUTATION

TEI

Conjoint Behavioral Consultation:
Treatment Evaluation Interview (TEI)

Child's Name:_____ Date:_____

Parent's Name:_____ Age:_____

Teacher's Name:_____ Grade:_____

School:_____

Consultant's Name:_____

TEI Goals:

* Determine if the goals of consultation have been obtained across settings.
* Evaluate the effectiveness of the treatment plan across settings.
* Discuss strategies and tactics regarding the continuation, modification, or termination of the treatment plan.
* Schedule additional interviews if necessary, or terminate consultation.

Conjoint Behavioral Consultation:
Treatment Evaluation Interview (TEI)

The consultant should question and/or comment on all of the following:

OPENING SALUTATION

EVALUATE GENERAL PROCEDURES AND OUTCOME

How did things go with the plan?

** Record treatment record here.

HOME	SCHOOL

QUESTIONS ABOUT GOAL ATTAINMENT

Has the goal of _____ been met at home/at school?

HOME	SCHOOL

If goals have been attained:

EVALUATE PLAN EFFECTIVENESS

Do you think that the behavior program was responsible for _____'s change in behavior?

HOME	SCHOOL

EVALUATE EXTERNAL VALIDITY OF PLAN

Do you think this plan would work with another child with similar difficulties?

HOME	SCHOOL

CONDUCT POST-IMPLEMENTATION PLANNING

Should we leave the plan in effect for a while longer?

HOME	SCHOOL

PROCEDURES FOR GENERALIZATION/MAINTENANCE

How can we encourage _____ to display these behavior changes in other problem settings?

What procedures should we use to make sure that the behavior change continues over time?

HOME	SCHOOL

If goals have not been attained:

QUESTIONS RE: PLAN MODIFICATION

How can we modify the procedures so that the plan is more effective across settings?

HOME	SCHOOL

FOLLOW-UP ASSESSMENT

How can we monitor _____'s progress to ensure that these positive changes continue?

HOME	SCHOOL

QUESTIONS RE: NEED FOR FUTURE INTERVIEWS

When can we meet again to discuss the effectiveness of our modified plan?

Would you like to meet again to check on _____'s progress?

TERMINATION OF CONSULTATION (If goals have been met)

CLOSING SALUTATION

Appendix O

Treatment Manuals

SOCIAL PROGRAM FOR PRESCHOOLERS

PARENT MANUAL

PARENT-TEACHER INTERVENTION PROJECT

Wisconsin Center for Education Research

University of Wisconsin-Madison

and

Dane County Head Start

Madison, WI

1992-1993

Table of Contents

INTRODUCTION

Children learn a great deal from playing and interacting with other children. It is a sign of developmental maturity when a child appropriately seeks out other children his/her age to play with. Children who do not attempt to interact socially with their peers may be at risk for school-related and social problems.

It is important for a child to work on his/her social skills both at home and Head Start, since the problems occur in both places. Both parents and teachers can help a child develop his/her social skills by setting up situations in which the child can play with other children and by modeling appropriate social skills.

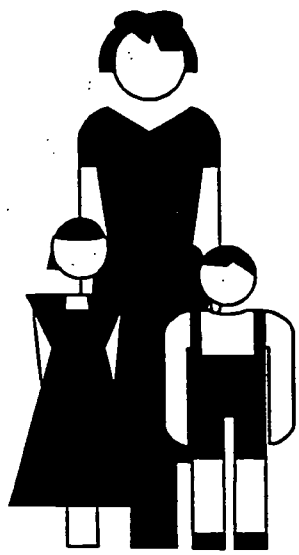
The purpose of this program is to get parents and teachers to work together to improve children's social skills both at home and Head Start. This manual provides parents tips for transferring those social skills learned at Head Start to the home setting.

There are *four main parts* to this program. These include:

* Skill Selection and Goal-Setting Procedures
* Positive Reinforcement
* Home-School Communication
* Peer Activities at Home

It is important to keep track of your child's social interactions during this program. You and your child will have a record of how well he or she is doing and areas where improvement is needed.

Since there are several parts in this program, checklists are provided at the end of this manual to help you remember the steps and to aid communication with your consultant. Each week, complete a checklist by placing a ✓ in the line beside the items you have completed.



SETTING-UP FOR SUCCESS

Problems are caused by many things. Sometimes, before tackling a problem head on, it helps if you step back and look at things that may be contributing to the problem and work on changing those first. Below are some things you might want to think about before getting started on this behavior improvement program with your child.

**Changing the environment.* Are there things in your home that you could change that would make it easier for your child to be good?

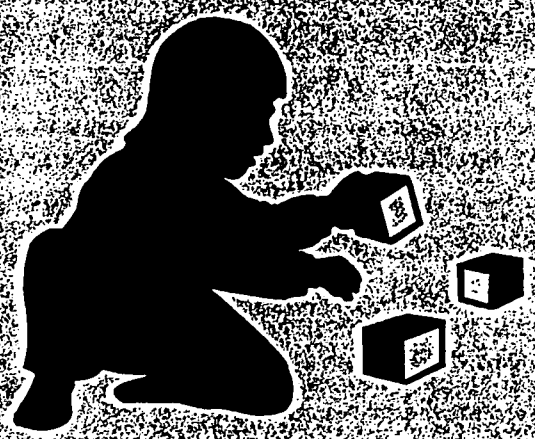
**Develop consistent routines.* Children are more comfortable if they know what to expect. Take a look at what problems are most likely to occur, and see whether a set routine might help.

**Make sure your commands or directions are clear, polite, and understood.* The way we tell someone to do something can have a big impact on their following directions.

**Teach new skills.* Your child may not know what to do, because he/she doesn't know *how* to do it. Could you teach your child what he/she needs to be able to interact with friends?

**Treat each other with respect, care, and love.* You may need to "bite your tongue" or, conversely, mention nice things that may otherwise be taken for granted.

SKILL SELECTION AND GOAL SETTING



BEST COPY AVAILABLE

SKILL SELECTION AND GOAL SETTING

The Skill Selection part of this program will help you and your child's Head Start teacher select an appropriate skill or behavior for your child to work on. Both you and your child's teacher completed the *Social Skills Rating System* (SSRS). Your responses indicated the social skills that you felt your child needed help with. You, your child's teacher, and the consultant will meet to discuss which of your child's social skills problems are most significant.

The social skill selected will then become your child's goal. One skill or area of concern will be worked on at a time! You can help your child learn and practice a skill through the following four steps:

TELL

* Tell your child about the skill, define it, and ask questions about it.
* Explain why the skill is important.
* Explain to your child the steps to learning the skill.

SHOW

* Model and practice the skill in a controlled situation.

DO

* Ask your child to tell *you* about the skill and why it is important.
* Ask your child to tell you the steps to learning the skill.
* Have your child practice the skill with you in another pretend situation.

SET GOAL AND PRACTICE

* Set a goal to have your child develop a skill.
* Have your child practice the skill daily in different situations with different people such as with a neighbor at home or with a friend at school.
* Set a goal to use the skill daily and practice.

Here is an example of the steps for the skill of "Joining Ongoing Activities or Groups without Prompting."

TELL

* Tell your child about the skill and ask questions about it.

"I want to talk about ways that you can join an activity or group of other kids without being asked to or without help from me or your teacher. Do you know what the word "join" means? Are there times when other kids are playing a fun game and you want to play too, but you don't know how? What are some things you can do to play with them?"

BEST COPY AVAILABLE

* Explain why the skill is important.

"It is important to learn how to join a group because an adult won't always be able to help you. Also, the other kids might not think to ask you to play with them. If they are playing a game you like to play, you need to learn how to ask them if you can play, too."

* Tell your child the steps to learning the skill.

1. Walk up to and look at a member of the group that you want to join.
2. Tell the person that you like the game or activity.
3. Ask if you can play.
4. If the person says "yes," play with them. If the person says "no," thank the members of the group anyway.
5. Thank the members of the group for letting you play.

SHOW

* Model and role-play the skill in a pretend situation.

Pretend with your child that some kids are playing tag or hide-and-seek and you want to join. Talk about the steps.

DO

* Ask your child to tell *you* about the skill and why it is important.

"What does it mean to "join" an activity? Why is it important to learn how to ask other kids if you can play with them?"

* Ask your child to tell you the steps to learning the skill.

"If there is a group of kids you want to play with, what do you need to do?"

* Have your child practice the skill in another pretend sitaution.

"Let's pretend that you're at the park and some kids are playing soccer and you want to join them."

SET A GOAL AND PRACTICE

GOAL-SETTING involves:

* You *and* your child developing goals for peer interactions.
* Forming a plan to meet the goal in your neighborhood.
* Figuring out how to meet the goal.
* Practicing the plan before using it with peers.

The purpose of *GOAL-SETTING* is to:

* Increase the chance of starting social interactions at home.
* Increase the chance of using these skills later on.
* Have your child practice joining a real-life activity, such as joining a group of neighborhood kids playing in the park.

Rules for effective *GOAL-SETTING:*

1. ***Choose a goal that your child has control over.***

   GOOD EXAMPLE: "I'll ask _____ to play after school."
   NOT-SO-GOOD EXAMPLE: "I'll play with _____ after school".

2. ***Choose a goal that tells your child what to do.***

   GOOD EXAMPLE: "I will ask Tiereka if I can play with him and Ben."
   NOT-SO-GOOD EXAMPLE: "I won't play by myself at the park today." (Doesn't tell child what he should do.)

3. ***Choose small goals that your child will probably achieve, especially at the beginning.***

   GOOD EXAMPLE: "I will ask Sarah to play on the swings with me."
   NOT-SO-GOOD EXAMPLE: "I will start a game at the park."

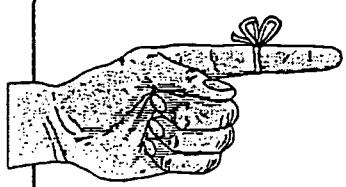
   *Choosing small goals will help to hook your child into the *GOAL-SETTING* process.

4. ***Make goals specific so your child can follow them.***

   GOOD EXAMPLE: "I will ask Luis to play ball at the park today."
   NOT-SO-GOOD EXAMPLE: "I will play with someone at the park."

5. ***Keep track of goals that are set on goal sheet.***

   *Review the goals and progress with your child.
   *Encourage and praise your child's effort and success.



REMEMBER:

* Discuss goals with your child
* Keep goals simple and specific
* Practice goals before trying them with peers
* Record goals and progress on goal sheet
* Encourage and praise your child's efforts

ERIC

Checklist
Skill Selection and Goal-Setting

_____Select a behavior of your child's to improve.

_____Involve your child in setting a goal for home play situations.

_____Tell your child about the behavior and state why it is an important behavior.

_____Show your child how to do the behavior.

_____Have your child show you that he or she can do the behavior.

_____Practice doing the behavior with your child in different situations.

POSITIVE REINFORCEMENT

BEST COPY AVAILABLE

POSITIVE REINFORCEMENT

It is often rewarding for children to keep track of their successes and to see their own progress on a home or school chart. However, your child should also realize how important their success is to you, and how proud you are of his or her progress. Thus, positive reinforcement, or "special rewards" should be provided after a goal is reached.

You and your child will select a reward as you set goals. It is important to chose a reward that your child will enjoy. When discussing the daily goal, your child should be allowed to choose the particular reward that he or she will work towards. A reinforcement "menu" or "survey" may be helpful in providing additional ideas and activities that you are willing to provide your son or daughter when they show appropriate behavior.

PROMPTING

An important component in an effective reinforcement program is prompting. Prompts help tell your child what to do to reach his or her goal. Depending on how difficult it is for your child to play with other peers currently, you may need to provide several prompts. Once the behavior occurs, it should be reinforced.

PRAISE

Praise is a valuable part of behavior programs because it is so flexible and easy to use. Praise has been shown to effectively increase a variety of child behaviors. If you praise your child whenever he or she is interacting with a peer, he or she will be more likely to interact with peers in the future. This praise provides feedback to your child that you have noticed and approved of his or her social behaviors.

Praising is especially important at the beginning of the program when social introductions or peer contacts may be very infrequent or of short duration. Thus, praise social behaviors most at the beginning, and then less frequently as they become more firmly established.

GUIDELINES FOR REINFORCEMENT PROCEDURES

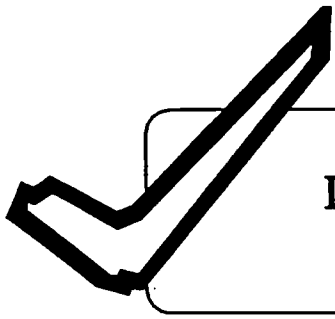
1. *Immediate reinforcement is best when establishing new social skills.* Praise your child right away when you see him or her playing with other children. A delay, such as complimenting a child at the end of the day for an appropriate social behavior performed in the morning, may not change his or her behavior.

2. *Reinforcement should occur frequently when establishing new social skills.* Behaviors may occur infrequently when they are just being developed. At first, praise your child every time you see him or her playing with other kids. Once you see your child playing often with other children, you won't need to reinforce him or her every time the behavior occurs.

3. *Be specific in the use of reinforcers.* When praising your child, tell him or her exactly why he or she is being praised. For example, you could say, "_____, I liked the way you asked _____ if you could play Shoots and Ladders with her."

4. *Identify events that are rewarding to your child.* Try to find out what kinds of things your child likes and will work hard for. You may want to make a list of several reinforcers and then allow your child to pick which one he or she would like to work for.

5. *Provide cues if necessary.* When developing new behaviors, children often need frequent reminders or prompts to know what to do. You can teach your child what to do by showing him or her, or pointing out what other kids do when playing with their peers.



Positive Reinforcement Checklist

___Have your child select a reward while setting a goal.

___Use prompts to help your child reach his or her goal.

___Use praise whenever your child is interacting with peers.

___Use reinforcement frequently, especially in the beginning.

___Tell your child how proud you are of his or her progress.

ERIC

HOME-SCHOOL COMMUNICATION

BEST COPY AVAILABLE

HOME-SCHOOL COMMUNICATION

Home-School communication is designed to keep you and your child's teacher actively informed of your child's progress. The primary goals of Home-School communication are to (a) help you and your child's teacher communicate regularly regarding your child's progress in the program; and (b) help your child think of ways that the skills practiced at school can be used in your neighborhood or community. Home-School communication should be followed by goal setting at home.

Meeting the Daily Goal. For your child to engage in similar appropriate social behaviors in play situations at home or in the neighborhood or community, it is important that parents and teachers become involved in each others' Goal-Setting Procedures. Every day, your child will bring home a daily goal sheet. At your first opportunity after school, ask your child how he did at meeting his goal that day. Specific questions that should be asked include:

1. What was your goal today?
2. What did you do to meet your goal?
3. Who did you play with?
4. Was it fun?
5. What else did you do at school today?

Each of these questions should be followed by specific and genuine praise. Following the discussion of your child's school day, it is important to ask your child how similar behaviors can be practiced in your neighborhood or other play situations.

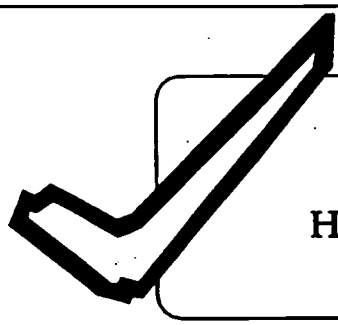
EXAMPLES: "Well, I'm glad to hear that you and _____ had such a fun time playing tag at recess today. Do any of your friends in the neighborhood like to play tag?"

Wait for your child's response. If your child responds positively, continue. If your child responds negatively, ask him for alternative activities that neighborhood peers enjoy playing.

For example, "What kinds of things do your friends in the neighborhood like to play?" "Can you play tag with _____, too?"

Wait for your child's response. If your child responds positively, provide praise, and prompt further. For example, "How can you do that?" If your child responds negatively, question why it would not be possible. In this case, it will be necessary for you to discuss alternatives with your child.

Not Meeting the Daily Goal. In some cases, your child may not meet his/her daily goal. In these cases, express mild disappointment, but encourage your child to try harder the next day. For example, you might say: "I'm sorry that you did not meet your goal today; I guess you'll have to try a little harder tomorrow. Let's see if you can meet your goal tomorrow."



Checklist

Home-School Communication

_____Ask child if he or she brought home the daily goal sheet and praise him or her for doing so.

_____Ask child if he or she met their goal.

_____Ask child how similar behaviors can be practiced at home or in the neighborhood.

_____Provide child with some examples for practicing the behavior at home.

_____Encourage child to work on his or her goal.

PEER ACTIVITIES AT HOME

BEST COPY AVAILABLE

PEER ACTIVITIES AT HOME

Children need to practice playing nicely with their peers. The Head Start Program provides children with many hours of "play with time." We want to encourage parents to create some positive peer "play with time" at home. We call this part of the program peer activities. In the remainder of this section, we explain peer activities and outline steps for using it.

WHAT ARE PEER ACTIVITIES: Your child plays with a friend two times a week in a 10-minute activity organized by a parent.

* Your child also will be involved in activities with classmates at school (every day).
* Your child's teacher will give you a report each week about some activities she is using with your child.

WHY USE PEER ACTIVITIES: They give your child chances to practice taking turns and talking with other children.

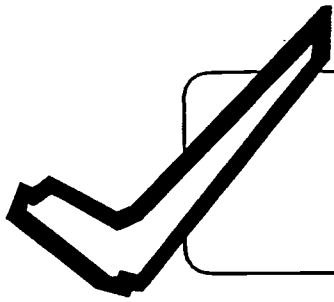
WHAT DO PEER ACTIVITIES LOOK LIKE: There are four types of peer activities in this program. They are:

1. Taking turns; no talking necessary
2. Taking turns; a little talking
3. Taking turns; your child talks a little more
4. Taking turns; your child starts a conversation and keeps it going

* You and the consultant will decide where to start
* You and the consultant will decide what behaviors to focus on, depending on your child's needs

STEPS FOR GETTING PEER ACTIVITIES GOING

1. With the consultant, you will decide on what type of activities to start with. Whenever possible, activities should be different from those used at school.
2. Pick out the materials you will need for the activity (for example, a game board).
3. Have your child and a friend join you in a place where you can do the activity.
4. Explain the activity and give directions.
5. Tell children what you expect to see. Examples: taking turns, talking about the game.
6. Praise your child and friend when you see them taking turns, talking appropriately.
7. End activity after about 10-15 minutes.



Checklist
Peer Activities at Home

_____Select appropriate peer activity for use in your home.

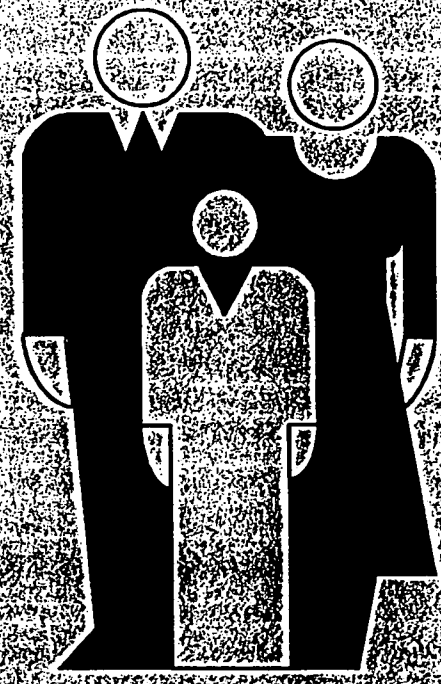
_____Help your child and his/her friend get started with the activity.

_____Clearly state to your child and the friend the important behaviors (turn taking and talking) you want to see.

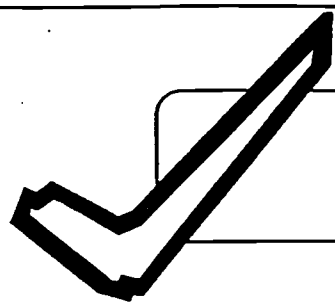
_____Praise your child and his/her friend when they show the desired behavior.

ERIC

PARENT CHECKLIST



BEST COPY AVAILABLE



PARENT CHECKLIST

Parent:_____

Directions:

The purpose of this checklist is to help you keep track of the many steps to this program and to communicate with your consultant about your efforts to help your child. At the *end of each week,* complete the following checklist.Place a check mark next to completed activities. If there are certain things that you are unsure of, please contact the consultant. The consultant will be available to provide feedback and suggestions.

After completing this checklist, please return it to the consultant. Thank you!

Skill Selection and Goal-Setting

___ Selected a behavior for improvement.
___ Involved your child in setting a goal for home play situations.
___ Told your child about the behavior and why it's important.
___ Showed your child how to do the behavior.
___ Had your child show you he or she can do the behavior.
___ Practiced doing the behavior with your child in different situations.

Positive Reinforcement

___ Had your child choose a reward to work towards when establishing the daily goal.
___ Provided specific and genuine verbal praise for goal attainment.
___ Provided the reward *immediately* following goal attainment.

Home-School Communication

___ Greeted your child and asked about his or her day.
___ Reviewed your child's goal sheet.
___ Praised your child for meeting his or her goal at school (if applicable), or encouraged your child to meet his or her goal the following day (if applicable).
___ Prompted neighborhood carry-over.
___ Asked your child for neighborhood examples.

Peer Activities at Home

___ Decided on what activities to start with.
___ Picked materials for the activity.
___ Had child and friend join you in activity.
___ Explained activity and gave directions.
___ Told children what to expect to see.
___ Praised your child and friend when appropriate.
___ Ended activity after about 10-15 minutes.

ERIC

TERMS TO REMEMBER

MONITOR = Keep track of.

MODEL = To show.

CUE = A signal.

PROMPT = Remind, assist.

INTERACTION = Playing, talking together.

PEER = Same aged friend.

REINFORCEMENT = Reward (that is, attention, praise).

ATTEND = Pay attention to child and comment.

COMMANDS = Instructions.

Overview of the Parent-Teacher Intervention Project (P-TIP)[1]

The P-TIP project is being conducted by Drs. Thomas R. Kratochwill and Stephen N. Elliott and several advanced graduate students in the School Psychology Program at the University of Wisconsin-Madison. This project focuses on the treatment of socially withdrawn and aggressive children, using consultation services from behavorial consultants. The research has received approval from the University of Wisconsin Human Subjects Committee and involves minimal or no risks for participants. The specific goals of the project are (a) to provide consultative services to parents and teachers, thereby encouraging a cooperative problem-solving relationship between the two; (b) to work collaboratively with parents and teachers to address the specific behavioral difficulties of children; and (c) to implement an effective behavioral program to remediate the difficulties exhibited by the nominated child.

This intervention manual is one of four manuals developed to facilitate understanding and implementation of multicomponent treatment plans. If you have any questions about this manual or the larger P-TIP project, please contact

Dr. Ingrid Sladeczek
453A Educational Sciences Building
Wisconsin Center for Education Research
University of Wisconsin-Madison
Madison, WI 53706
(608) 263-3386

[1]This manual was created by Drs. Thomas R. Kratochwill and Stephen N. Elliott with the assistance of Dr. Ingrid Sladeczek and Michele Plunge. We would also like to acknowledge that previous work by Pamela Carrington Rotto and Susan Sheridan greatly influenced this manual. Development of this manual was supported by a grant from the Office of Special Education and Rehabilitative Services, U. S. Department of Education (H023C20172-92), and by the Wisconsin Center for Education Research, School of Education, University of Wisconsin-Madison. Any opinions, findings, or conclusions are those of the author(s) and do not necessarily reflect the views of the supporting agencies.

ERIC

BEHAVIOR PROGRAM FOR PRESCHOOLERS

PARENT MANUAL

PARENT-TEACHER INTERVENTION PROJECT
Wisconsin Center for Education Research
University of Wisconsin-Madison
and
Dane County Head Start
Madison, WI

1992-1993

Table of Contents

INTRODUCTION

Children learn a great deal from playing and interacting with other children. It is a sign of maturity when a child properly seeks out other children his or her age to play with. Children who do not try to interact socially with their peers or those who interact aggressively may be at risk for school-related and social problems.

It is important for a child to work on his or her social skills both at home and at Head Start, since the problems can occur in both places. Both parents and teachers can help a child develop social skills by setting up situations in which the child can play with other children and by modeling appropriate social skills.

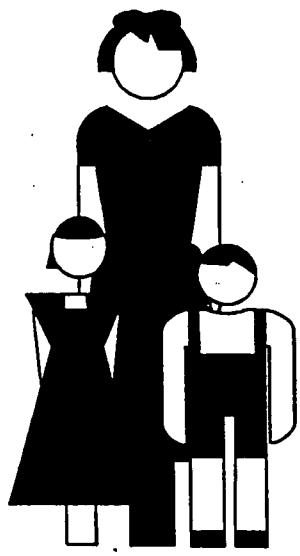
The purpose of this program is to get parents and teachers to work together to improve children's social skills both at home and at Head Start. This manual provides parents tips for transferring those social skills learned at Head Start to the home setting.

There are *four main parts* to this program. These include:

* Skill Selection and Goal-Setting Procedures
* Child Management
* Home-School Communication
* Peer Activities at Home

It is important to keep track of your child's social interactions during this program. You and your child will have a record of how well he or she is doing and areas where improvement is needed.

Since there are several parts in this program, checklists are provided at the end of each section and at the end of this manual to help you remember the steps and to aid communication with your consultant. Each week, complete a checklist by placing a ✓ on the line beside the items you have completed.



SETTING-UP FOR SUCCESS

Problems are caused by many things. Sometimes, before tackling a problem head on, it helps if you step back and look at things that may be contributing to the problem and work on changing those first. Below are some things you might want to think about before getting started on this behavior improvement program with your child.

**Changing the environment.* Are there things in your home that you could change that would make it easier for your child to be good?

**Develop consistent routines.* Children are more comfortable if they know what to expect. Take a look at what problems are most likely to occur, and see whether a set routine might help.

**Make sure your commands or directions are clear, polite, and understood.* The way we tell someone to do something can have a big impact on their following directions.

**Teach new skills.* Sometimes children don't perform the way we'd like because they lack the skill, not the motivation. Could your child use more direct instruction?

**Treat each other with respect, care, and love.* You may need to "bite your tongue" or, conversely, mention nice things that may otherwise be taken for granted.

**Encourage parental growth and well-being.* We all need time for ourselves, away from our kids. What are some interests you could pursue each day that would be personally positive?

SKILL SELECTION AND GOAL SETTING

BEST COPY AVAILABLE

SKILL SELECTION AND GOAL SETTING

The Skill Selection part of this program will help you and your child's Head Start teacher select an appropriate skill or behavior for your child to work on. Both you and your child's teacher completed the *Social Skills Rating System* (SSRS). Your responses indicated the social skills that you felt your child needed help with. You, your child's teacher, and the consultant will meet to discuss which of your child's social skills problems are most significant.

The social skill selected will then become your child's goal. One skill or area of concern will be worked on at a time! You can help your child learn and practice a skill through the following four steps: Tell, Show, Do, and Practice.

TELL

1. Tell your child about the skill and ask questions about it.
2. Explain why the skill is important.
3. Tell your child the steps to learning the skill.

SHOW

Model and practice the skill in a controlled situation.

DO

1. Ask your child to tell *you* about the skill and why it is important.
2. Ask your child to tell you the steps to learning the skill.
3. Have your child practice the skill with you in another pretend situation.

SET GOAL AND PRACTICE

1. Set a goal to have the child develop a skill.
2. Have your child practice the skill daily in different situations with different people such as with a neighbor at home or with a friend at school.

Here is an *example* of the steps for teaching the skill of "Joining Ongoing Activities or Groups Without Reminding."

TELL

– Tell your child about the skill and ask questions about it.

> "I want to talk about ways that you can join an activity or group of other kids without being asked to or without help from me or your teacher. Do you know what the word "join" means? Are there times when other kids are playing a fun game and you want to play too, but you don't know how? What are some things you can do to play with them?"

ERIC

BEST COPY AVAILABLE

– Explain why the skill is important.

"It is imporatnt to learn how to join a group, because an adult won't always be able to help you. Also, the other kids might not think to ask you to play with them. If they are playing a game you like to play, you need to learn how to ask them whether you can play, too."

-- Tell your child the steps to learning the skill.

1. Walk up to and look at a member of the group that you want to join.
2. Tell the person that you like the game or activity.
3. Ask whether you may play.
4. If the person says "yes," play with them. If the person says "no," thank the members of the group anyway.
5. Thank the members of the group for letting you play.

SHOW

-- Model and role-play the skill in a pretend situation.

Pretend with your child that some kids are playing tag or hide-and-seek and you want to join. Talk about the steps.

DO

– Ask your child to tell *you* about the skill and why it is important.

"What does it mean to "join" an activity? Why is it important to learn how to ask other kids if you can play with them?"

– Ask your child to tell you the steps to learning the skill.

"If there is a group of kids you want to play with, what do you need to do?"

– Have your child practice the skill in another pretend sitaution.

"Let's pretend that you're at the park and some kids are playing soccer and you want to join them."

SET A GOAL AND PRACTICE

GOAL-SETTING involves:

– You *and* your child developing goals for peer interactions.

– Forming a plan to meet the goal in your neighborhood.

– Figuring out how to meet the goal.

– Practicing the plan before using it with peers.

The purposes of *GOAL-SETTING* are to:

– Increase the chance of starting social interactions at home.

– Increase the chance of using these skills later on.

ERIC

Rules for effective *GOAL-SETTING:*

1. *Choose a goal that your child has control over.*

   Good example: "I'll ask ___ to play after school."
   Not-so-good example: "I'll play with ___ after school". (___ may not be able to play.)

2. *Choose a goal that tells your child what to do.*

   Good example: "I will ask Ben if I can play with him and Tiereka."
   Not-so-good example: "I won't play by myself at the park today." (Doesn't tell child what he should do.)

3. *Choose small goals that your child will probably achieve, especially at the beginning.*

   Good example: "I will ask Sarah to play on the swings with me."
   Not-so-good example: "I will start a game at the park."

   *Choosing small goals also will help to hook your child into the *GOAL-SETTING* process.

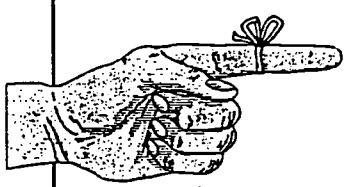
4. *Make goals specific so your child can follow them.*

   Good example: "I will ask Luis to play ball at the park today."
   Not-so-good example: "I will play with someone at the park."

5. *Keep track of goals that are set on goal sheet.*

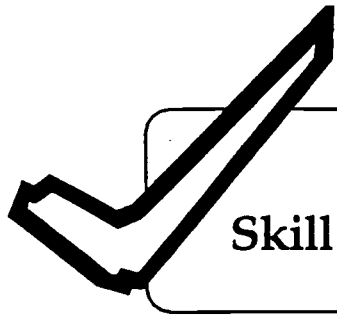
   *Review the goals and progress with your child.

   *Encourage and praise your child's effort and success.



REMEMBER:

* Discuss goals with your child
* Keep goals simple and specific
* Practice goals before trying them with peers
* Record goals and progress on goal sheet



Checklist
Skill Selection and Goal-Setting

_____Select a behavior of your child's to improve.

_____Involve your child in setting a goal for home play situations.

_____ Tell your child about the behavior and state why it is an important behavior.

_____Show your child how to do the behavior.

_____Have your child show you that he or she can do the behavior.

_____Practice doing the behavior with your child in different situations.

CHILD MANAGEMENT:

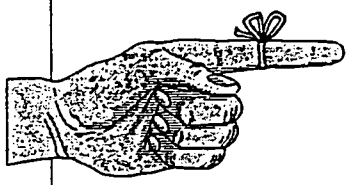
DIFFERENTIAL ATTENTION • INSTRUCTION GIVING • TIME AWAY

BEST COPY AVAILABLE

DIFFERENTIAL ATTENTION

Differential attention involves attending to your child, rewarding your child when he or she is behaving appropriately, and ignoring your child when he or she is behaving inappropriately. Of course, it is not always possible to ignore all inappropriate behaviors, so you will have to make some important decisions when using differential attending.

There are two important reasons for using differential attention. First, *when a child's behavior is followed by something good, s/he probably will act that way again. Second, most children will work for attention from others, especially parents.* The attention can be either positive (for example, praise) or negative (for example, criticism, scolding) in nature. A child who is not receiving positive attention may work to receive negative attention, which s/he considers to be more desirable than no attention at all.



REMEMBER:

Differential Attending involves three parts:

1. Attending
2. Rewarding
3. Ignoring

PART I. ATTENDING

HOW TO SHOW ATTENDING

You will be providing your child a running description on his or her activity. Your descriptive comments provide a more constant source of attention than one-time or occasional rewards (that is, praise statements). You can provide consistent opportunities to let your child know which specific behaviors you like. Make comments about behavior *you can see* and *emphasize prosocial or positive behaviors.*

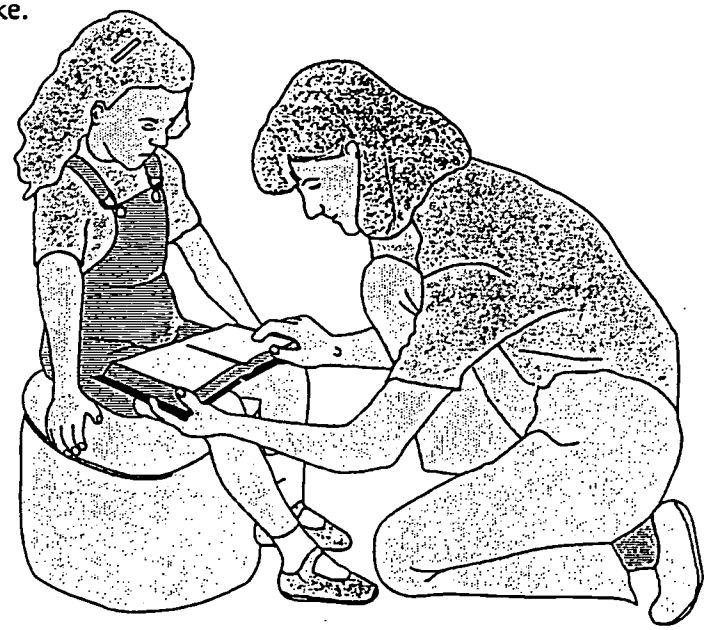
EXAMPLES:

1. Describe behavior you can see.
   Example: "You are stacking blocks."
   "Here comes the truck."

2. Emphasize prosocial or positive behavior.
   Example: "You are playing nicely with your toys."
   "You are talking in a normal voice."
   "You are taking turns with your brother."

STEPS FOR USING ATTENDING

1. Introduce play time and allow your child to choose the activity.
2. Watch what your child is doing, and then begin to describe what she or he is doing aloud. You may describe behavior you can see (for example, "You're stacking blocks.") or emphasize positive behavior (for example, "You are talking in a normal voice.").
3. Hand your child materials, take a turn, or copy what she or he is doing as you comment on his or her behavior.
4. Do *not* ask questions or tell your child to do things.
5. Do *not* teach your child or test his or her knowledge.
6. Accept the things your child does, unless clearly inappropriate or dangerous.
7. Provide praise, approval, or honest feedback about what you like about your child's play. Ignore what you don't like.
8. Relax and have FUN!



PART II. ATTENDING AND REWARDING

Positive statements or praise and physical affection are powerful rewards that all parents can offer children who are behaving appropriately.

You can teach your child which behaviors you like, so that she or he can do them more often. Punishing bad behavior only provides information about what *not* to do. All children will work for positive attention and rewards from parents.

REWARDING CHILDREN FOR GOOD BEHAVIOR

There are three types of rewards that parents can use to reward good or desired behavior.

1. Labeled verbal rewards

Labeled verbal rewards are positive praise statements, specifically describing good or appropriate behavior. When your child does something you want to see repeated, identify the particular behavior in a positive manner. This type of reward should be used most.

Examples: "I like it when you sit quietly."
"You listened well to my directions, good job!"
"I like it when you share your candy with me."

2. Unlabeled verbal rewards

Unlabeled verbal rewards are positive praise statements that tell a child she did something good or acceptable, without saying the specific behavior. This tells your child that you like something she has done or is doing.

Examples: "Wonderful!"
"You are doing great!"
"That's really good, Jay!"
"Maria, excellent!"

3. Physical rewards

Physical rewards involve physical affection that communicates approval to the child.

Examples: smiling
hugging
clapping

STEPS FOR USING ATTENDING AND REWARDING

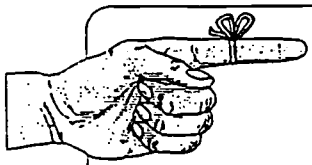
1. Use attending and rewards together, whenever possible. This strategy will tell your child *exactly what she or he did or is doing that pleases you.*

2. Attending and rewards should be used following desirable behaviors to help increase those behaviors.

3. Use *labeled verbal rewards* frequently to describe good behavior. Also use unlabeled verbal rewards and physical rewards.

4. Reward your child as soon as possible after seeing a good or desired behavior.

5. Use rewards often, but only for desired behavior.



REMEMBER:

Always try to give a REWARD and an ATTENDING STATEMENT together. Whenever possible, reward your child IMMEDIATELY specifying the desired behavior. Be consistent in your use of rewards.

ERIC

PART III. ATTENDING, REWARDING, AND IGNORING

Teaching children how to behave includes two steps. First, you must teach your child what you want him to do. Second, you must teach your child what you don't want him to do. When your child is doing something you don't like (that is, problem behaviors such as temper tantrums or not minding you), *you can ignore the behavior to let him know that you disapprove.* Behavior tends to decrease when it is ignored or does not receive attention.

Ignoring has three parts:

(1) No eye contact or nonverbal cues,

(2) No verbal contact, and

(3) No physical contact.

STEPS FOR USING IGNORING

1. *Make no eye contact or nonverbal cues.* Turn away from the child (preferably with your back to the child).

2. *Make no verbal comments.* Do *not* talk at all with your child once the ignoring procedure has started.

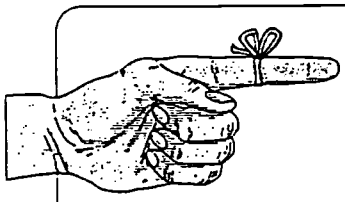
   (a) Do *not* explain why you are ignoring at this time. (Do so later when your child is behaving appropriately.)

   (b) Do *not* respond if your child asks why she or he is being ignored.

   (c) Explain in advance: "Brandon, I am going to ignore you when you are not behaving appropriately (or following my directions). That means I am going to turn around and not say anything to you. As soon as you begin behaving well (or following my directions), I will stop ignoring you."

3. *Make no physical contact.* It is a good idea to stand when ignoring, to prevent your child from attempting to sit on your lap or tugging at you. This strategy also provides a cue for your child so that he realizes that he is being ignored.

In severe cases, you may find it necessary to leave the room to avoid paying attention to your child. The disadvantage to this procedure is that you may not be aware when the inappropriate behavior has ceased.



REMEMBER:

Ignoring is a simple but often powerful means of changing a child's behavior if you usually provide attention when the child is behaving appropriately.

When your child's inappropriate behavior stops, reinforce appropriate behavior *immediately.*

Whenever your child's behavior is damaging or has the potential to damage himself, others, or property, use a more active intervention.

SUMMARY: PUTTING IT ALL TOGETHER

Discipline alone will not teach a child good behavior. You also need to provide positive attention when your child is behaving well. Rewarding and attending tell your child when you like what s/he is doing. In other words, you want to *Catch Your Child Being Good, and Then Let Them Know You Like Their Behavior.*

STEPS FOR USING ATTENDING, REWARDING, AND IGNORING

A. Find a time when your child is playing with something enjoyable and appropriate. You should try to spend at least 15 to 20 minutes each day playing with your child. The child is to select what she wishes to play, and it is essential that you give NO HELP with this decision. In addition, no other children should be involved in this "special time."

B. Watch your child's activities for a few moments to get some idea of what she is doing.

C. Describe your child's behavior. You might think of yourself as a sportscaster at a baseball game, or you might pretend that there is a blind person in the room and you must describe to that person what your child is doing.

D. Do *not* ask questions or give commands during this play time. You will find this step difficult because most parents interact with their child primarily through questions.

E. Occasionally, provide your child with positive, genuine feedback using positive statements about what you like that the child is doing. For example, "I like it when you and I play quietly together." AVOID comments about what your child is *not* doing. For instance, "I enjoy it when you don't throw toys around the room."

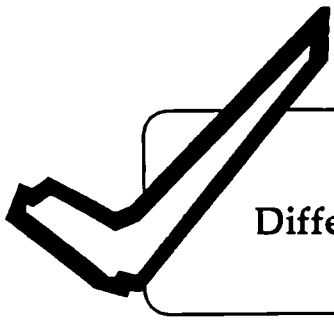
F. If your child begins to misbehave, simply turn away and attend to something else in the room. If the misbehavior continues or gets worse, then leave the play area immediately. Come back and play with your child later when s/he is behaving more appropriately.

G. If another child tries to become involved (and many siblings do when they see you paying attention to another child), tell the other children that you cannot play at this time, but will spend "special time" with them alone later. If both parents are living at home, then one can take the other children away from the play area while the other plays with the child of concern.

H. *Each* parent should try to spend at least 15 minutes with the child alone each day.

I. If the child becomes extremely disruptive or abusive during play, then discipline the child the way that you normally would. Later you will learn other strategies for effectively disciplining the child during such times.

ERIC



Checklist

Differential Attending Skill Sequence

_____Casually watch child with interest.

_____Join in when it seems appropriate.

_____Describe what child is doing out loud.

_____Avoid asking questions, issuing commands, or teaching.

_____Tell child what you like about his/her play.

_____Reward child for desirable behavior.

The above checklist provides a summary of the major steps involved in carrying out differential attending. We have found that frequent use of such a checklist helps remind parents of specific skills they have and should be using with their child to improve his or her behavior.

INSTRUCTION GIVING

Instruction-giving skills are used to get your child to do the things that you ask him to do. These skills also are used to get your child to stop doing the things you find undesirable. Instruction-giving skills do not replace the attending skills you already have mastered. Be sure to continue to praise and attend to your child's desirable behaviors. Continue to ignore minor problem behaviors. Be consistent with the behaviors you decide to ignore. Instruction-giving skills are effective only when used in combination with differential attending skills. Different parent instructions may encourage desirable or undesirable child behaviors.

PAYING ATTENTION TO YOUR CHILD'S FOLLOWING OF DIRECTIONS

Although you earlier learned how to pay attention to your child's play during special time, you can now use these attending skills to provide approval when your child follows a command or request. *When you give a command, it is necessary that you give your child immediate feedback regarding how well she is doing.* Don't leave the area to do something else, stay and attend by positively commenting on your child's following your instructions.

WHAT MAKES AN INSTRUCTION EFFECTIVE

Effective instructions have seven important characteristics.Read through the list below and think about your son or daughter and how you can use effective instructions with him or her.

1. *Be specific and direct.*
   a. Get your child's attention by calling her by name and pausing until eye contact is established.Your voice should be *firm* and slightly *louder* than usual.
   b. Give the child a simple, clear instruction such as "Please shut the door."
   c. Phrase the instruction as a "do" command rather than a "stop" command whenever possible.
   d. Do *not* use a question when you want your child to do something.
   e. Say exactly what is meant using words the child understands and try to avoid lengthy directions with two or three parts.
2. *Give one command at a time.* If there are several tasks to be completed, give a separate command for each.
3. *Follow the command with a wait of 8-10 seconds.* Do not talk to your child until your child begins to do the task.
4. *Praise your child when s/he follows directions.* Praise or attend to your child immediately when he does what you want.
5. *If your child does not follow directions, follow the command with a warning.*
   a. Do not repeat your command. This will help stop you from becoming angry as you repeatedly ask your child to do something.
   b. Warnings are "If . . . , then . . ." statements. For example, "If you choose not to pick up your toys, then . . . ." Give warnings in a stern, firm voice so that your child knows you are serious.
   c. Make sure your warnings are stated clearly and encourage your child to assume responsibility for his actions. For example, "Tony, this is a warning.If you choose not to turn off the Nintendo game, then (*state a consequence*)."

6. *Again, praise your child for following directions, even if it occurs after the warning.*

7. *Give the consequence if your child does not follow directions within 8-10 seconds following the warning.*

COMMANDS TO AVOID

When giving your child instructions, try to avoid long vague commands. Below is a list of *four types of commands that are generally ineffective* with children.

1. ***Chain commands.*** A series of commands strung together, especially when they require the completion of several unrelated activities. For example: "Pick up the blocks and put them in the box. Then make your bed, and put the dirty clothes in the hamper."

2. ***Vague commands.*** These instructions do not specify observable behaviors to be performed by the child. They present an unclear situation for the child. For example: "Be careful," "Watch out, " and "Be a good boy."

3. ***Question commands.*** Many commands and requests used by parents are phrased as questions. Problems occur when a parent expects a child to follow directions but phrases it as a request. For example: "Would you like to take your bath now?"

4. ***Lengthy commands.*** Commands should be kept short and to the point. Try to avoid lengthy explanations. For example, use "Please put away the toys in your room" instead of "Please put away the toys in your room. We're having company tonight and I'd like the house to look nice."

STEPS FOR GIVING INSTRUCTION

1. Get your child's attention.

2. Give a specific, brief command or direction that you know your child can carry out.

3. As soon as you have given a command or request and your child begins to obey, praise the child for following directions. BE SPECIFIC! Try to use labeled verbal rewards.

   Examples: I like it when you help set the table.
   It's nice when you pick up your clothes.
   Thanks for clearing your dishes when asked.
   Look at how fast you are picking up your toys.
   Thanks for going to bed when asked.

   Use any statement that specifically tells your child that you appreciate that s/he is doing what was asked.You can also use physical contact to show your approval.

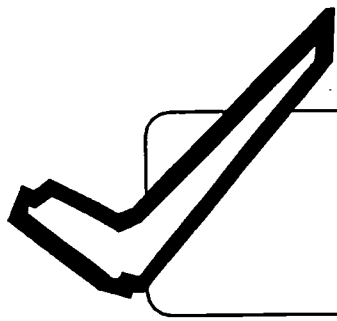
4. When your child follows directions, you may leave the area if necessary. However, you must be sure to return frequently to continue praising your child's following of directions.

5. If your child does a job or chore without being told to do so, provide positive praise to your child.You may also provide your child with a small privilege for having done the job without being told.

6. You should make a special effort to give positive attention to your child for almost every command you give.

ERIC

BEST COPY AVAILABLE



Checklist
Instruction-Giving Sequence

_____Obtain child's attention.

_____Issue instruction. Wait 8-10 seconds.

_____Repeat instruction with verbal warning. Wait 8-10 seconds.

_____Praise your child when h/she follows directions.

_____If your instruction is not complied with, deliver discipline.

This checklist serves to summarize the major steps in giving your child an instruction.Please use it to help you remember the steps and to monitor your own progress toward giving effective instructions.

ERIC

TIME AWAY

There are two ways to decrease a child's undesirable behavior. You can use differential attending skills (that is, attending, rewarding, and ignoring) and instruction-giving skills to get your child to do the things that you ask him to do or you can use a time away procedure to get your child to stop doing the things you find undesirable. Time away also is useful for stopping inappropriate behavior before it becomes aggressive or assaultive, or for serious violations of family rules.

Time away is an interruption of a child's bad or unacceptable behavior by removing him from a situation for a brief period of time (3-5 minutes). Removal of the child stops the behavior from occurring and takes the child away from whatever events are encouraging the behavior to occur. Some people also call this procedure time-out.

USING TIME AWAY

Time away requires skill and care to use effectively when your child misbehaves or fails to follow directions. You should give instructions only when you intend to follow up with consequences to see that your child complies. Always provide praise and approval when your child obeys your first request. Try as much as possible to avoid repeating your command after it has been said once. But if you must repeat a command and your child does not follow it, consider using time away as a consequence for your child's failure to follow directions.

To use time away effectively, you will need to make some preparations.

1. You will need a small portable kitchen timer.
2. Select a place for time away. This location must be *a dull place* where your child cannot view the television or family activities. It also should not be a place where toys are located. In addition, the time away location should *not* be in a dark, scary, or dangerous place. *The goal is to remove your child from a fun place to a place where nothing is happening.*
3. All care-providers in the home must agree in advance which behaviors will result in time away. Remember, *consistency is critical.*
4. Before using time away for disciplinary purposes, practice using it with your child during a time when your child is not in trouble.

Tell your child that there are *two rules* when in time away:

Rule 1: The timer will start only when the child is quiet. After your child is quiet, if she begins to yell, cry, or say unpleasant things, the timer stops. Once the child is quiet again, the timer will begin all over again.

Rule 2: If your child leaves time away before the timer rings, you will lead her back to time away without saying a single word and restart the timer when she is quiet. If your child refuses to be lead back to the time away location, you will give a warning (that is, If..., then...) with a specific consequence. Plan in advance what the consequence will be. Some parents take away a privilege such as watching a special TV program or take away a favorite toy for 2 days as a back-up consequence when time away does not work effectively.

ERIC

STEPS IN USING TIME AWAY

1. Always obtain your child's attention before giving your first command. This instruction should be presented in a firm but pleasant voice. Do not yell at the child, but also *do not ask a favor. Your instruction should be a simple, direct statement to your child.*

2. After you have given the instruction, count silently to 10. Do not count aloud, because your child would learn to rely on this counting to decide when to follow directions. If your child follows your direction, attend to his positive behavior with a praise statement or pleasant touch.

3. If your child does not follow directions within the 10 seconds, you should make direct eye contact, raise your voice to a slightly stronger level and firmly deliver a warning.

   "*(Child's name)*, this is a warning. If you choose not to *(state desired action)*, then you are going to *(give consequence)*."

   Decide in advance which behaviors will result in time away. In these situations, you should inform your child that the consequence will be spending time away.

4. If your child does not follow directions within 10 seconds of the warning, then firmly state, "You *(specify the exact behavior)* , so you must spend time away." You should say this without yelling. Your child is to go to the chair immediately, regardless of any promises she may make.

   Your child is not to go to the bathroom, get a drink, or stand and argue with you before leaving. Time away is *immediate.*

5. If your child resists going to the time away chair, calmly guide him/her to the chair. Remember, once you say TIME AWAY to your child, do not speak with her again until the required quiet time in the designated location is completed.

   Please note: If calmly guiding the child is not effective in getting your child to begin a time away, a different strategy will be suggested.

6. When your child is sitting *quietly* in the designated time away location, leave the time-away area and set the timer for the specified number of minutes. As a general rule, use 1 minute of quiet time for each year of life. For example, a four-year-old should have 4 minutes.

   If your child makes noises, talks, screams, or cries, reset the timer without saying a word to your child. Follow this strategy each time your child makes noises.

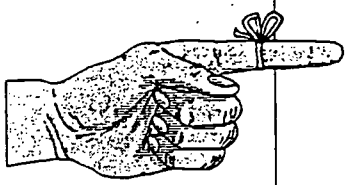
7. If your child leaves the time-away location before the quiet time is over, use the following procedures:

   (a) Lead her back to the location without saying a single word, other than to restate the rule. Restart the timer when she is quiet.

   (b) If the above step is not effective, you also may give your child a choice of remaining in the chair *or* receiving a specific consequence. This consequence should be delivered immediately following the time-away sequence, and it should not be a long-term punishment.

8. After your child has remained quiet and in the designated time-away location for the required amount of time, the timer will ring. Go to your child and say, "You have been quiet, you are finished now." Do not discuss, remind, or nag your child about what she did wrong.

9. *Immediately* repeat the original instruction that your child refused. The child must complete the task or activity she originally was asked to do.



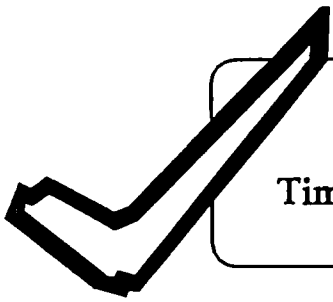
PLANNING AHEAD IN CASE YOU NEED TO USE TIME AWAY

REMEMBER:

1. Select the behaviors that will result in a time away in advance. Briefly inform your child of these behaviors.
2. Avoid using repeated warnings, because they teach your child not to listen to you the first time.
3. Don't nag, scold, or talk to your child when s/he is in time away. Remember, your child is not allowed to speak to anyone until the time away is over.
4. Remain calm at all times.
5. You are to decide when your child has completed her/his time away.
6. Time away should be brief enough so that your child has many chances to come back to the original situation and to try to correct the behavior (or complete the specified task). To remain away for lengthy time periods is ineffective because the child may fall asleep or become interested in something new. It is better to have many short time-outs for small, negative behaviors than to prohibit your child from play or family activities for the rest of the day, evening, or week.

Make some critical decisions now by addressing the following four aspects of time away.

1. Behaviors that will result in time away:_____
2. Number of minutes for child's time away: _____
3. Time away location: _____
4. Procedure for use when child refuses to go to or remain in time away:



Checklist
Time Away Sequence of Actions

_____ Get child's attention.

_____State which directions the child has not followed.

_____Give directions for child to go to time-away chair or location.

_____Use no other verbal cues when stating directive.

_____Use no nonverbal cues other than to point to time-away chair or area. Wait 10 seconds.

_____Guide child to time-out, if necessary.

_____Set timer for _____ minutes.

_____Return child to chair or time-away area, if necessary.

_____ Restate rule during return.

_____Use no other verbal or threatening nonverbal cues.

_____ Monitor child, but give no direct attention.
Adjust timer if child is noisy or leaves time-away area.

_____Announce end of time away.

_____Make no comments regarding misbehavior.

_____Restate request.

SUMMARY GUIDELINES FOR INCREASING YOUR CHILD'S GOOD BEHAVIORS

A. *Praise your child immediately* when he is doing something that pleases you (for example, playing quietly, doing homework, sharing with siblings, minding you). When you praise your child, say exactly what the child is doing that pleases you.

B. *Check on your child frequently* so you have lots of chances to praise good behavior. At first check every 5 minutes. Then, slowly add a minute or so to how long you wait before checking the child again. Never leave a young child longer than 10 minutes without checking to be sure everything is okay.

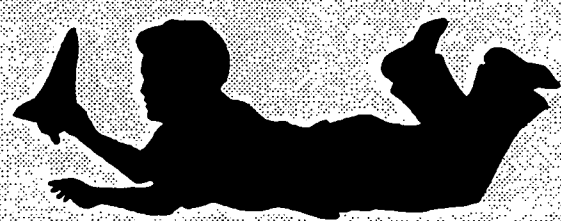
C. *Do not leave "well enough" alone* by ignoring calm, pleasing behaviors. Avoid falling into a trap where you don't want to disturb or interrupt your child. If your child does something you like and you don't praise him/her, your child will learn that if she behaves; mom or dad will ignore her. When you provide positive attention for good behavior, you are teaching your child that good behavior receives more attention than inappropriate behavior.

D. *Keep your praise brief.* Your attention does not need to interrupt your child's activity. It's best to catch your child being good several times each day, spending just a few seconds praising a specific behavior that pleases you.

E. *Ignore inappropriate behavior.* Follow the rules stated previously.

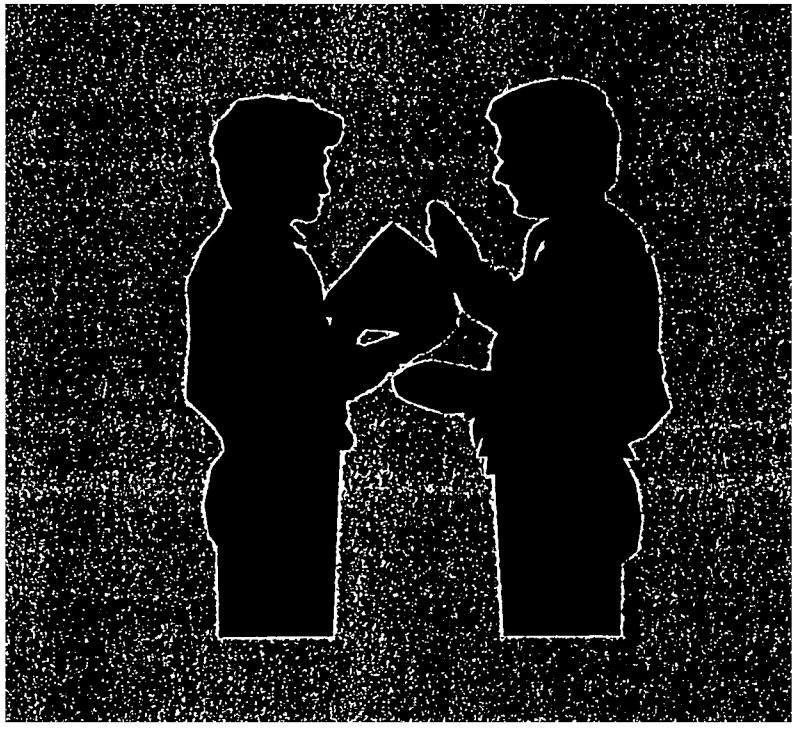
F. *Avoid directing your child's activities.* Describe what you see in a positive statement.

Examples: "I see that you are playing nicely with the blocks."
"Wow, great job sharing your toys!



BEST COPY AVAILABLE

HOME-SCHOOL COMMUNICATION



BEST COPY AVAILABLE

HOME-SCHOOL COMMUNICATION

Home-School communication is designed to keep you and your child's teacher actively informed of your child's progress. The primary goals of Home-School communication are to (a) help you and your child's teacher communicate regularly regarding your child's progress in the program and (b) help your child think of ways that the skills practiced at school can be used in your neighborhood or community. Home-School communication should be followed by goal setting at home.

Meeting the Daily Goal. For your child to engage in similar appropriate social behaviors in play situations at home or in the neighborhood or community, it is important that parents and teachers become involved in each others' Goal-Setting Procedures. Every day, your child will bring home a daily goal sheet. At your first opportunity after school, ask your child how he did at meeting his goal that day. Specific questions that should be asked include:

1. What was your goal today?
2. What did you do to meet your goal?
3. Who did you play with?
4. Was it fun?
5. What else did you do at school today?

Each of these questions should be followed by specific and genuine praise. Following the discussion of your child's school day, it is important to ask your child how similar behaviors can be practiced in your neighborhood or other play situations.

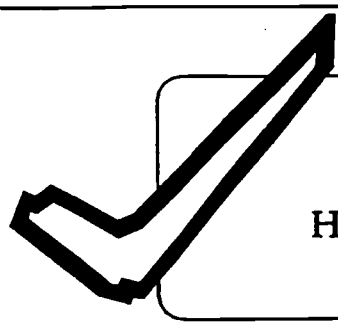
EXAMPLES: "Well, I'm glad to hear that you and _____ had such a fun time playing tag at recess today. Do any of your friends in the neighborhood like to play tag?"

Wait for your child's response. If your child responds positively, continue. If your child responds negatively, ask him for alternative activities that neighborhood peers enjoy playing.

For example, "What kinds of things do your friends in the neighborhood like to play?" "Can you play tag with _____, too?"

Wait for your child's response. If your child responds positively, provide praise, and prompt further. For example, "How can you do that?" If your child responds negatively, question why it would not be possible. In this case, it will be necessary for you to discuss alternatives with your child.

Not Meeting the Daily Goal. In some cases, your child may not meet his/her daily goal. In these cases, express mild disappointment, but encourage your child to try harder the next day. For example, you might say: "I'm sorry that you did not meet your goal today; I guess you'll have to try a little harder tomorrow. Let's see if you can meet your goal tomorrow."



Checklist

Home-School Communication

_____Ask child if he brought home daily goal sheet. Praise him if he did.

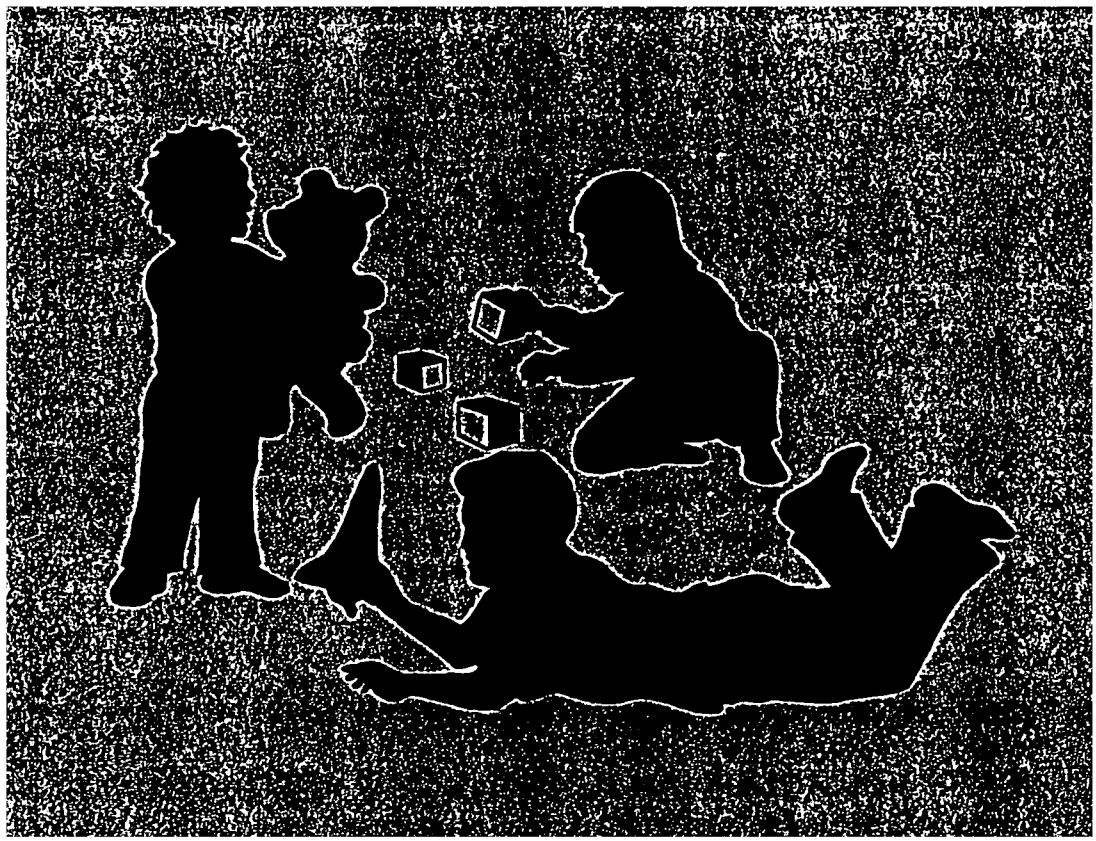
_____Ask child if she met her daily goal.

_____Ask child how similar behaviors can be practiced at home or in the neighborhood.

_____Provide child with some examples for practicing the behavior at home.

_____Encourage child for working on his or her goal.

PEER ACTIVITIES AT HOME



BEST COPY AVAILABLE

PEER ACTIVITIES AT HOME

Children need to practice playing nicely with their peers. The Head Start Program provides children with many hours of "play with time." We want to encourage parents to create some positive peer "play with time" at home. We call this part of the program peer activities. In the remainder of this section, we explain peer activities and outline steps for using it.

WHAT ARE PEER ACTIVITIES: Your child plays with a friend two times a week in a 10-minute activity organized by parent.

* Your child also will be involved in activities with classmates at school (every day).
* Your child's teacher will give you a report each week about some activities she is using with your child.

WHY USE PEER ACTIVITIES: They give your child chances to practice **taking turns and talking** with other children.

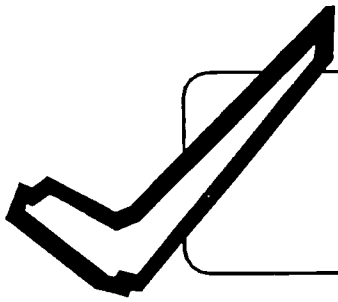
WHAT DO PEER ACTIVITIES LOOK LIKE: There are *four* types of peer activities in this program. They are:

1. Taking turns; no talking necessary
2. Taking turns; a little talking
3. Taking turns; your child talks a little more
4. Taking turns; your child starts a conversation and keeps it going

* You and the consultant will decide where to start
* You and the consultant will decide what behaviors to focus on, depending on your child's needs

STEPS FOR GETTING PEER ACTIVITIES GOING

1. With the consultant, you will decide on what type of activities to start with. Whenever possible, activities should be different from those used at school
2. Pick out the materials you will need for the activity (for example, game board)
3. Have your child and a friend join you in a place where you can do the activity.
4. Explain the activity and give directions.
5. Tell children what you expect to see. Examples: taking turns, talking about the game.
6. Praise your child and friend when you see them taking turns, talking appropriately.
7. End activity after about 10-15 minutes.



Checklist
Peer Activities at Home

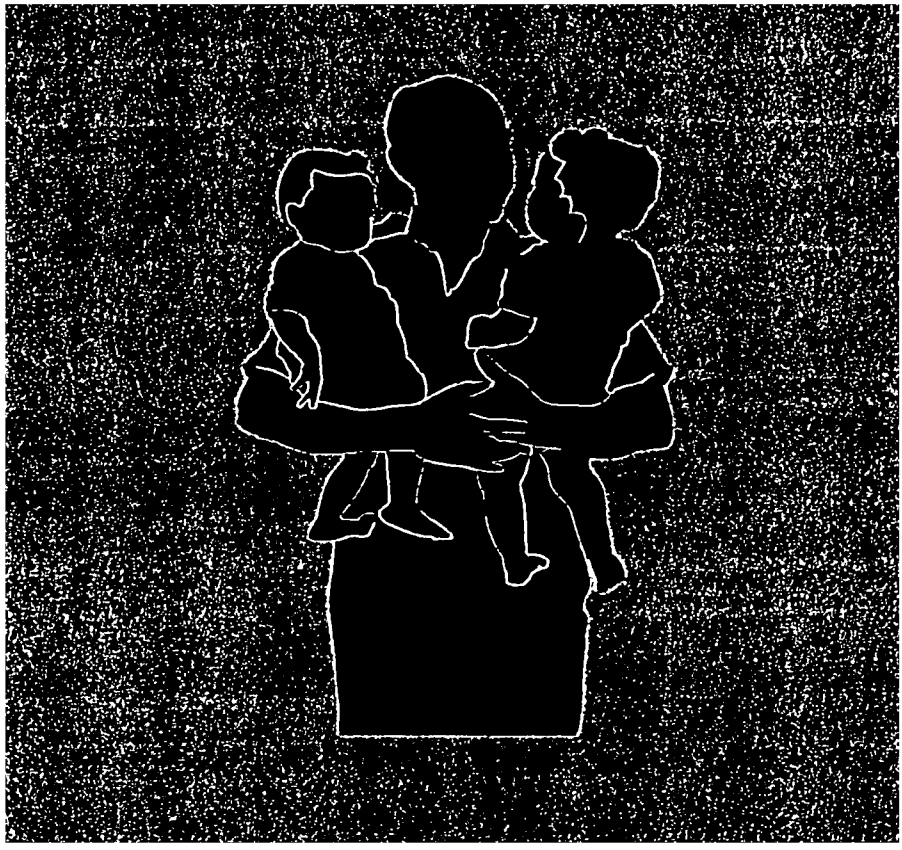
_____Select appropriate peer activity for use in your home.

_____Help your child and his/her friend get started with the activity.

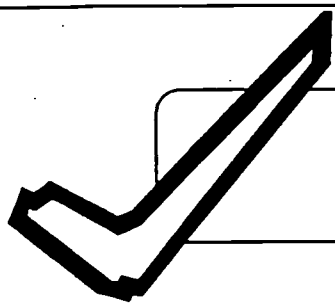
_____Clearly state to your child and the friend the important behaviors (turn taking and talking) to see.

_____Praise your child and his/her friend when they show the desired behavior.

PARENT CHECKLIST



BEST COPY AVAILABLE



PARENT CHECKLIST

Parent Name:_____ Date:_____

Directions:

This checklist will help you keep track of the many steps to this program and communicate with your consultant about your efforts to help your child. At the *end of each week,* place a check mark next to completed activities. If there are certain things that you are unsure of, please contact the consultant. The consultant will be available to provide feedback and suggestions.

After completing this checklist, please return it to the consultant. Thank you!

Skill Selection and Goal-Setting

___ Selected a behavior to improve.
___ Involved your child in setting a goal for home play situations.
___ Told your child about the behavior and why it's important.
___ Showed your child how to do the behavior.
___ Had your child show you s/he can do the behavior.
___ Practiced doing the behavior with your child in different situations.

Attending and Rewarding

___ Provided specific genuine verbal praise for goal attainment.
___ Provided the reward soon following goal attainment.

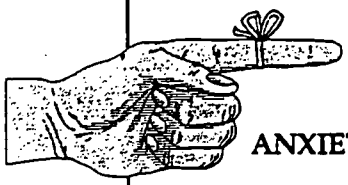
Home-School Communication

___ Greeted your child and asked about his/her day.
___ Reviewed your child's goal sheet.
___ Praised your child for meeting his/her goal at school (if applicable), or encouraged your child to meet his/her goal the following day (if applicable).
___ Prompted neighborhood carry-over.
___ Asked your child for neighborhood examples.

Peer Activities at Home

___ Decided on what activities to start with.
___ Picked materials for the activity.
___ Had child and friend join you in an activity.
___ Explained activity and gave directions.
___ Told children what to expect to see.
___ Praised your child and friend when appropriate.
___ Ended activity after about 10 minutes.

ERIC



TERMS TO REMEMBER

ANXIETY = Worry.

MONITOR = Keep track of.

MODEL = To show.

CUE = A signal.

PROMPT = Remind, assist.

INTERACTION = Playing, talking together.

PEER = Same aged friend.

INITIATION = To start.

REINFORCEMENT = Reward (that is, attention, praise).

ATTEND = Pay attention to child and comment.

WARNING = For if you _____, then _____.

PROSOCIAL = Positive behavior with friends.

COMMANDS = Instructions.

Overview of the Parent-Teacher Intervention Project (P-TIP)[1]

The P-TIP project is being conducted by Drs. Thomas R. Kratochwill and Stephen N. Elliott and several advanced graduate students in the School Psychology Program at the University of Wisconsin-Madison. This project focuses on the treatment of socially withdrawn and aggressive children, using consultation services from behavioral consultants. The research has received approval from the University of Wisconsin Human Subjects Committee and involves minimal or no risks for participants. The specific goals of the project are (a) to provide consultative services to parents and teachers, thereby encouraging a cooperative problem-solving relationship between the two; (b) to work collaboratively with parents and teachers to address the specific behavioral difficulties of children; and (c) to implement an effective behavioral program to remediate the difficulties exhibited by the nominated child.

This intervention manual is one of four manuals developed to facilitate understanding and implementation of multicomponent treatment plans. If you have any questions about this manual or the larger P-TIP project, please contact

Dr. Ingrid Sladeczek
453A Educational Sciences Building
Wisconsin Center for Education Research
University of Wisconsin-Madison
Madison, WI 53706
(608) 263-3386

[1]This manual was created by Drs. Thomas R. Kratochwill and Stephen N. Elliott with the assistance of Dr. Ingrid Sladeczek and Todd Gorges. We would also like to acknowledge that previous treatment manuals by Pamela Carrington Rotto and Susan Sheridan influenced this manual. Development of this manual was supported by a grant from the Office of Special Education and Rehabilitative Services, U. S. Department of Education (H023C20172-92), and by the Wisconsin Center for Education Research, School of Education, University of Wisconsin-Madison. Any opinions, findings, or conclusions are those of the authors and do not necessarily reflect the views of the supporting agencies.

ERIC

Appendix P

Interview Integrity Checklists

PROBLEM IDENTIFICATION INTERVIEW

Goals:

1. To mutually construct a clear problem definition with the consultee.
2. To develop procedures for data collection.

Indicate the occurrence of each interview objective.

Interview Objective	Occurrence	Notes
1. Opening Salutation		
2. General Statement		
3. Behavior Specification		
a. Specify examples		
b. Specify priorities		
4. Behavior Setting		
a. Specify examples		
b. Specify priorities		
5. Identify Antecedents		
6. Identify Sequential Conditions		
7. Identify Consequences		
8. Summarize and Validate		
9. Behavior Strength		
10. Summarize and Validate		
11. Tentative Definition of Goal		
12. Assets Question		
13. Existing Procedures Question		
14. Summarize and Validate		
15. Data Recording, Directional Statement		
16. Data Recording, Procedures		
17. Summarize and Validate		
18. Date to Begin Recording		
19. Date of Next Appointment		
20. Closing Statement		

278

BEST COPY AVAILABLE

PROBLEM ANALYSIS INTERVIEW

Data Sheet

Date: _____ Observer: _____

Client: _____ Reliability Observer: _____

Consultee: _____ Session #: _____

Consultant: _____

Interview Objective:	Occurrence:	Response:
1. Opening Salutation		
2. General Statement		
3. Behavior Strength		
4. Behavior Conditions		
(a) antecedent		
(b) consequent		
(c) sequential		
5. Summarize and Validate		
6. Interpretation		
7. Plan Statement		
8. Summarize and Validate		
9. Continuing Data Collection		
10. Establish Date of Next Appointment		
11. Closing Salutation		

BEST COPY AVAILABLE

TREATMENT EVALUATION INTERVIEW

Data Sheet

Date: _____ Observer: _____

Client Script: _____ Reliability Observer: _____

Consultant: _____ Session #: _____

Interview Objective	Occurrence:	Response:
1. Opening Salutation	_____	_____
2. Outcome Questions	_____	_____
3. Goal Attainment Questions	_____	_____
4. Internal Validity	_____	_____
5. External Validity	_____	_____
6. Plan Continuation	_____	_____
7. Plan Modification Validation	_____	_____
8. Generalization and Maintenance	_____	_____
9. Follow-up Assessment	_____	_____
10. Future Interviews	_____	_____
11. Termination of Consultation	_____	_____
12. Closing Salutation	_____	_____

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

☐ This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☑ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").