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VIDEO TRAINING FOR PARENTS OF EXCEPTIONAL CHILDREN

Judith R. Mathews

A Thesis submitted in partial fulfilment

of the requirements for the Degree of

MASTER OF SCIENCE

from

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Halifax, Nova Scotia

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ABSTRACT

Although the number of functional illiterates in Canada is astonishingly high, most training programs for parents of exceptional children require them to read a manual. The Baker manuals probably represent the most useful format, but are rated by the Flesch readability yardstick as requiring a Grade 13 education. In this study a series of 9 videotapes, which require minimal reading ability, was created, developed, implemented, and evaluated. These tapes were intended to teach parents of exceptional children instructional programming and behaviour management skills.

A total of 17 families attended a series of 9 group-training sessions. The parents represented a variety of educational backgrounds, although the majority had at least a Grade 10 education. Their children, who were all developmentally delayed, varied in abilities and handicaps.

Although 5 families dropped out, among the remaining 12 families there was a significant improvement ($p>0.01$) in the parents' knowledge of the principles, and all children but one learned at least one task from the commercially-produced RADEA curriculum. Seven families were videotaped teaching their children a skill, and the parents' performances were scored. With one exception, all demonstrated implementation to criterion of at least 75% of the techniques pinpointed as target skills.

In addition, all 12 families were interviewed at one month after completion of the course. Ninety-two percent were still teaching a skill, and 75% had generalized the behavioural principles to other behaviours.

Parents who completed the course generally gave positive evaluations of both individual sessions and of the course as a whole. More sessions

on behaviour management were frequently suggested. Families with severely limited education were too few to establish the unique effectiveness of the tapes for functionally illiterate parents. Nonetheless, suggestions are provided for improving the videotapes, and recommendations are made for similar studies in the future.

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CHAPTER 1

INTRODUCTION: PURPOSE OF THE STUDY

Training parents to teach their own exceptional children and systematic efforts at evaluating that training have evolved only since the early 1960s. Within the specific context of the application of behavioural principles, the most effective approaches have included the use of groups, modelling, multi-media presentation, and an educational combination that imparts both general principles and specific techniques. There have, of course, been difficulties. One of these has been the problem of dropout.

Investigation of dropout has pointed to three variables associated with high attrition rates:

1. low level of education in the parent (Bagel *et al.*, 1977),
2. lax criteria for entrance (O'Dell, 1974), and
3. depression in the parent (McMahon *et al.*, in press).

In an attempt to alleviate these problems, some professionals carefully screen parents for depression and place strong contingencies on attendance; but educational level remains a serious difficulty because most programs are centred on a manual or text, which often makes reading program information a prerequisite for further training. And, although some texts are rated by Flesch's Reading Ease Formula (Flesch, 1948) as having as low as a Grade 7 level of comprehension, many parents complain that they find it difficult to read for information, even when the vocabulary is simple.

This project is based on the premise that it is possible to impart the necessary information in a video format, and that by using the principles of programmed instruction, modelling, and role-playing, the problem

of parent educational level can be largely circumvented.

The rationale for the use of the video format is as follows:

Adult Illiteracy Figures

The Canadian Association for Adult Educators defines a "functional illiterate" as anyone (1) 15 years or older, who is (2) out of school without any other training, and (3) has achieved Grade 8 or less. Clearly, this definition presents some difficulties, as a person may qualify accordingly to the three criteria and yet have excellent reading skills. However, based on this definition, Statistics Canada states that, according to the 1971 census figures, 34.74% of all Canadians are functionally illiterate. Figures for functional illiterates in the Maritimes are as follows: Nova Scotia, 33.76%; New Brunswick, 44.72%; Newfoundland, 47.92%; and Prince Edward Island, 40.08% (see Appendix C for more detailed figures). Of those defined as functionally illiterate, it is estimated that one-fifth are totally illiterate.

Because most parent-training programs use a manual as the primary mode of imparting information, there is a large segment of the population who cannot benefit from the advances made in teaching exceptional children.

Availability to a Wider Audience

Currently in Nova Scotia services for parents of exceptional children are focussed in more populated areas and primarily in Halifax. By offering video training to local resource individuals (such as public health nurses or special educators), a cost-effective, portable training program could be used to educate parents in rural areas of Nova Scotia who must

now travel to larger centres for information: Thus the problems of illiteracy, geography, and the scarcity of high-demand mental health personnel can be overcome.

Familiarity with Television as a Mode of Communication

Because most families own a television and many people rely on it as their primary source of information and entertainment, a videotaped instructional package has the advantage of being a familiar mode of communication. One can speculate that for a number of North Americans television may have actually replaced written communication.

The implications for use of the videotapes are intriguing. Tapes could be broadcast on local cable television stations. The advent of home video means that parents could borrow tapes to be viewed in their own homes at their own convenience, which implies a greater potential to reach the entire family, as well as relatives, neighbours, and babysitters. Videotapes are versatile, because of one's ability to replay segments of special interest and pause for discussion or inspection of a particular technique.

In conclusion, a videotaped format offers several advantageous features: availability to a wider audience and to individuals who do not use reading as their primary source of information, either by choice or because of lack of reading skills; ability to use the tapes both individually and in groups, in the local community or in the home, and with close professional supervision or the monitoring of a paraprofessional.

CHAPTER 2

REVIEW OF RECENT LITERATURE

Prior to 1960, the child with emotional, developmental, or physical problems was dealt with primarily by professionals: by the therapist in the clinic, by the teacher in the classroom. However, even during the forties it was recognized by some that treatment of children should involve the parents. Group involvement of parents developed as a result of shortages of therapists during the second World War. But from then until the sixties, parent involvement was aimed at changing their attitudes, not at training them in behavioural techniques, and there was virtually no data collection (Davis, 1947; MacNamara, 1963; Munro, 1952; O'Dell, 1974).

Approaches to parent training have been compared, with a variety of outcomes. In comparing behavioural and reflective approaches, Cobb and Medway (1978) cite five studies in which the results range from no difference when measuring the child's behaviours (Johnson, 1970) or the parents' behaviour and attitudes (Anchor & Thomason, 1977) to inconclusive results (Dubey *et al.*, 1977; Frazier & Mathers, 1975), to one study (Tanormia, 1975) which showed the superiority of the behavioural method. Cobb and Medway hastened to point out that this latter study was conducted with developmentally delayed children.

Other studies support Cobb and Medway's findings regarding the effectiveness of the behavioural approach in the training of parents of developmentally delayed children (Benassi & Benassi, 1973; Garth, 1979; Heifetz, 1977; Hendrickson, 1977). For this reason, the review of the parent-training literature shall be limited to studies using a behavioural approach.

While Skinner's theories about learning were developed earlier in the century, it was not until the sixties that his theory of behaviour modification was used in applied settings with parents. Pumroy (1965) was probably the first to apply Skinner's techniques to parent training (O'Dell, 1974). Emphasis then shifted from a focus on altering attitudes to one of modifying behaviour. The question which was being asked was whether changing parents changes children.

While the shift in emphasis brought signficant improvement, it was not until later in the sixties that research was redirected from the case study method towards the empirical collection of data (O'Dell, 1974), an approach that increases confidence in the results and enables one to generalize them. In his review of parent training in *Behaviour Modification*, O'Dell (1974) comments that two-thirds of the research done in the area has been done since 1968. The more recent studies address themselves to a number of issues: effectiveness with various types of problems; effectiveness with various types of approaches; characteristics of parents most likely to be successful in parent training; reliability and validity of the measures; and cost efficiency. Each of these issues shall be reviewed individually, as they are all pertinent to the present study.

Review of Issues in Parent Training

Types of problems

Parent training has been used to deal with a variety of problems:

1. non-compliance (Forehand *et al.*, 1979; Patterson & Fagot, 1967);
2. aggression (Patterson & Reid, 1973; 1975);
3. autism (Koegal *et al.*, 1978; Kozloff, 1979; Mathis, 1971);
4. toilet training (Foxx & Azrin, 1975);

5. developmental delay in children (Arnold *et al.*, 1977; Baker *et al.*, 1976; Benassi & Benassi, 1973; Garth, 1979; Heifetz, 1977; Tymchuk, 1975; Watson & Bassinger, 1974); and

6. brain damage in children (O'Dell, 1974; Patterson *et al.*, 1965; Salzinger *et al.*, 1970).

Types of approaches

Individual versus group training. Group approaches to parent training were initiated for two primary reasons: (1) cost efficiency, and (2) to provide an opportunity for parents with similar problems to interact. Salzinger *et al.* (1970), Patterson *et al.* (1973), and Heifetz (1977) all used group approaches and report changes in the behaviour of the parents and children in the desired direction. Forehand *et al.* (1979) used individual parent training and also reported positive change in both parent and child. There are differing opinions as to whether group training is more efficient. Christensen *et al.* (1980) reported that, when comparing parents who received individual treatment, group treatment, and minimal contact bibliotherapy, the former two approaches were superior to the third, but that there was no difference between individual and group approaches on parent attitude (as measured by the Becker Bi-polar Adjective Checklist) and collected data of the defined problem (i.e., the number of compliant and noncompliant responses to commands given by parents). While Hirsch (1968) found no difference in success between 5- and 10-person groups, Sadler *et al.* (1976) found that the attrition rate decreased when the group had fewer than 5 members.

Specific training procedures

Content. There have been several studies conducted which investigated the nature of the content of parent training programs. The approaches used include:

1. teaching the principles of social learning theory (Mira, 1970);

2. teaching specific techniques to be used with individual children, which involve pinpointing, recording, and changing antecedents and consequences (Forehand *et al.*, 1977, 1979; Zeilberger *et al.*, 1968), and the latter in combination with information regarding social learning theory (Patterson *et al.*, 1974, 1975; Salzinger *et al.*, 1970; Walder *et al.*, 1969).

O'Dell *et al.* (1977) investigated the skills needed in order to implement behavioural change. Their study compared:

1. didactic pretraining in behavioural principles,
2. placebo pretraining, and
3. no pretraining.

They found no differences among the three groups. Home implementation measures, however, tended to improve with the briefer training period. In contrast, Flowgower and Sloop (1976) found that mothers receiving instruction in both behavioural principles and specific techniques were more able to generalize to other situations and other children. The small sample (n=4) makes their conclusions tentative.

Use of manuals. Programmed texts commonly used include Patterson's (1977) and Becker's (1971). Patterson and Reid (1973) report some desired change in parents exposed to the Patterson text alone. Baker *et al.* (1976)

developed a series of training manuals of a similar format to be used with developmentally delayed children. Baker and Heifetz compared a self-administered manual condition to a control condition and found the former to be superior. The self-administered manual condition was found to be equal to or somewhat superior to a group session, but inferior to an individual training approach. Christensen *et al.* (1980) compared a minimal contact bibliotherapy group to group and individual training and found the bibliotherapy group to be inferior to the other conditions.

Parent-training manuals have been evaluated according to levels of readability by Flesch's Reading Ease Formula and compared by Bernal and North (1978); they range from the Grade 7 level (Becker, 1971) to Grades 13 to 16 (Baker *et al.*, 1976). Little data are available regarding the effectiveness of the various manuals; Bernal and North cite Baker *et al.* (1976) as the most impressive of the studies of such manuals. The high reading level required, however, limits its usefulness with a number of parents.

Modelling. Modelling has been found to be a very effective technique for teaching parents. Johnson and Brown (1969) found modelling to be superior to instruction, discussion, or cueing with a signalling device.

Extending modelling to include behavioural rehearsal has been used by Johnson (1971) and using videotapes for feedback on specific rehearsal techniques was implemented by Bernal *et al.* in 1972 (O'Dell, 1974).

Use of audio-visual materials. Audio-visual materials are used for two primary purposes: (1) for instruction, i.e., demonstration of techniques to be learned; and (2) for feedback on the actual performance of

the student (or parent). Since the late 1960s, there has been considerable interest in the use of television for instructional purposes. As an alternative to live instruction, numerous studies have yielded no significant difference in the students' performance (Kirschner *et al.*, 1975; see Campbell and Cass under the heading of Television). In spite of these results, which seem to indicate that the cost-efficient method of television instruction is equally as effective as live presentation, its use in lieu of live presentation is neither widespread nor popular. Most studies of this nature, however, involve instruction in an educational setting, primarily at the university level, and in most instances, use of the videotapes precluded the presence or involvement of a live instructor.

In numerous parent-training programs, the use of film or videotape to model the desired behaviour is included in the overall training program (Heifetz, 1976; Patterson, 1974; Walder *et al.*, 1969). Goldstein *et al.* (1966) found videotapes to be effective in modelling behaviour (Christensen *et al.*, 1978).

Findings in the area of feedback are consistently positive. Kirschner *et al.* (1975) cite numerous examples of the effective use of videotaping to give the student feedback on attitudes and/or performance. More specifically, videotapes have been used effectively to provide feedback to parents on their management techniques (Bernal, 1969; Bernal *et al.*, 1972; Johnson, 1971).

In addition to the use of videotaping for giving feedback, various cueing devices have been used effectively. The 'bug-in-the-ear' as a device to give instant feedback to the parent has been used with success in

the laboratory setting (Forehand, 1979). Other cueing devices used in the clinical setting include cueing with light signals (Wahler, 1969) and hand signals (O'Leary *et al.*, 1967). Christensen *et al.* (1980) used an audio system to obtain intermittent data regarding behaviour in the home. The device was automated to record at intervals and was used for collecting data to be later analyzed in the clinic.

Heifetz (1974) comments that research on media effectiveness has been minimal and that inclusion of media techniques has been as part of a larger 'package' to be evaluated. There is little evidence that this situation has changed over the past six years in the area of parent training.

Programmed instruction. Historically, programmed instruction stemmed from the work of B. F. Skinner, who initially viewed its use as a relatively rigid set of techniques. These included the requirements that: (1) the learner work at his/her own pace and individually; (2) the work be organized in small steps, carefully sequenced; and (3) the response (which must be overt) to each step yield immediate feedback and determine the direction of future steps (Hartley, 1974). Research on Skinner's techniques has not shown a significant difference between his approach and a more traditional teaching approach (Hartley, 1974).

Hartley states that Skinner's rigid structure is not appropriate under all circumstances, and that one must look at the audience to determine the appropriateness of the components. In general, he states that for lower-ability learners, immediate knowledge, overt responding, and the use of small steps was more effective. For brighter students, the steps were sometimes too small and the active responding and immediate

knowledge of results were frustrating.

Since Skinner's initial approach, the concept of programmed instruction has expanded considerably and the flexibility in approach has yielded better results. At present, the most important components of the approach include: (1) setting behavioural task objectives and structuring the materials to meet these objectives systematically; (2) assessing the achievement of those objectives; and (3) revising the steps to improve the implementation if the assessment indicates its necessity.

Bhushan (1971) conducted a study in the use of programmed instruction with lower socio-economic status biology students and found that "programmed instruction, as compared with conventional classroom teaching, is more effective for the students who belong to a lower S.E.S. than for other students" (p. 219).

Kirschner *et al.* (1975) quote a study by Gary Taylor (p. 25), entitled "A Comparative Evaluation of Teaching Effectiveness and Efficiency of Teaching Effectiveness and Efficiency for Three Presentation Modes--Programmed Multimedia for Groups, Programmed Textbook, and Multimedia Lecture-Discussion--as Adapted from an Original Unit of Instruction." Results found the programmed multimedia approach significantly more effective and the programmed textbook more efficient. His conclusion is that a combination of the two would be ideal.

A further expansion of the concept of programmed instruction includes its use in group training. Meyer (1979) discusses two types of group instructional approaches, for use in in-service education and staff development: (1) use of modules. Meyer defines a module as "a self-contained, independent, self-paced unit of work programmed to a set of objectives"

(p. 23). It is usually a unit of an extended course.

(2) Use of a minicourse. Meyer's definition of a minicourse is as follows: "A fully self-contained flexible miniature course for individuals or groups usually involving a variety of media and strategies and with specific objectives achievable in a short span of time, usually a few days or less; based on an educational technology model; not packaged for independent learning; never a unit of an extended course" (p. 25). The minicourse offers a training manual and stresses group interaction. Meyer's particular program is designed to allow expansion into decentralized learning centres in rural areas, by training course leaders. Preliminary evaluative studies of the more than 60 minicourses which Meyer has designed have yielded positive results.

Contingencies for parents. As stated at the outset, attrition in parent groups has been a problem. A variety of incentives has been used. Peine and Munro (1973) found that social rewards, monetary reimbursement and written contracts (O'Dell, 1974) improved attendance and participation. Patterson *et al.* (1974), Eyberg and Johnson (1974), and Rinn (1975) used reimbursement of a portion of the initial fee for each session of attendance and completion of assignments. The last three studies mentioned compared performance with and without monetary incentive. Their results showed an increase in attendance and completion of assignments in the groups who were offered contingencies.

Generalization

There has been considerable concern regarding generalization of information and techniques taught to parents. Forehand has published a

number of studies (Forehand & Atkeson, 1977; Forehand *et al.*, 1979; Humphreys *et al.*, 1978) which are concerned with the generality of treatment effects. Four types are recognized: (1) temporal, (2) setting, (3) behavioural, and (4) sibling.

A fading-out procedure is frequently used in an attempt to implement temporal generality (Patterson *et al.*, 1973). No studies have specifically investigated the effectiveness of fading out. Forehand *et al.* (1979) found that behaviour which was taught to parents of noncompliant children using his approach was maintained at 6- and 12-month follow-ups.

Setting generality is probably the area of most concern in the studies which deal with parent training. A number of approaches include home training or a combination of home training and clinical training (Patterson *et al.*, 1969) or home assignments (Christensen *et al.*, 1980; Forehand & King, 1974; Heifetz, 1976). No studies have looked at the effects of this procedure in isolation from other treatment procedures (Forehand & Atkeson, 1977).

Other approaches to generality include discussion with the parents (Forehand *et al.*, 1974) and simulated home environments in the clinic (Forehand & Atkeson, 1977). Studies in behavioural generality are investigated in terms of the effectiveness of teaching behavioural principles versus specific techniques versus a combination of both (see page 12 for details).

Characteristics of parents

Parents who are more highly educated and have higher socioeconomic status are more likely to consistently attend (Gabel *et al.*, 1977; Speer

et al., 1968) and to implement effective changes (Rinn *et al.*, 1975; Salinger, 1970, in Cobb & Medway, 1978). Salinger believes that this is true primarily because of the approaches used and that the results would be better with less educated parents if there were more modelling and individualization. O'Dell (1974) concurs with Salinger.

In general, studies have eliminated any parents with psychiatric problems. McMahon *et al.* (in press) found that there was a higher incidence of dropout with parents who were depressed and of lower socio-economic status. He suggests that for such a group, it may be important to alter the amount of individual attention given and the contingencies.

Measurement

What is measured?

The child's behaviour. Initially, emphasis was placed primarily on measuring the child's behaviour (Bernal, 1969; O'Dell, 1974), using a single case study method and an ABAB or multiple baseline approach. Success in treatment is seen as a change in the behaviour in the desired direction. A number of recent studies, however, have used the child's behaviour as one of several outcome measures. Heifetz (1974), for example, used the Behaviour Assessment Manual as one of six outcome measures.

The parent's behaviour. Concern with generalization over time, behaviour, and setting (Forehand *et al.*, 1979) makes the therapist concerned about the parent's behaviour as well as the child's. The parent must be able to effectively implement an approach in order for there to be lasting results.

Parent behaviour has generally been measured as parent-child interactions. Herbert and Baer (1972) described the parents' verbal statements; Patterson *et al.* (1972) developed a behavioural coding system which delineated specific categories of defined parent interactions with the child. Forehand *et al.* (1978) developed a very detailed coding system which measures maternal antecedents and consequences and the child's response. Forehand also introduced the terms "alpha commands" (i.e., a command to which a response is appropriate) and "beta commands" (i.e., a command to which there is no opportunity for compliance).

The parent's knowledge of behavioural principles. Becker (1971) and Patterson (1977) included questions demonstrating knowledge of principles in their programmed texts. Heifetz (1974) had a "Behavioural Vignettes Test" in which parents were asked to answer how they would handle given situations. O'Dell (1974) developed a measure called "Knowledge of Behaviour Principles as Applied to Children" (KBPAC). This measure is reported to have a Kuder-Richardson reliability coefficient of 0.93, an odd-even split-half coefficient of 0.93, and a standard error of 2 (O'Dell *et al.*, 1977). In addition, O'Dell (1974) used films of individual children's behaviours and required the parent to simulate handling the situation. The parent's behaviour was then recorded.

The parent's attitudes towards the child and/or towards therapy. The most commonly-used measure of parent attitude is the Becker Adjective Checklist-Patterson Revised (BAC) (Patterson *et al.*, 1972). Heifetz developed his own attitude questionnaire, which is geared specifically

to parents of developmentally delayed children (Heifetz, 1974). Other assessments of parent attitudes towards their children include: the Eyberg Child Behaviour Inventory, which asks the parent to give a rough measure of how often a behaviour occurs and whether or not it is a problem to the parent; and three measures used by Forehand: Characteristic Attitudes and Behaviour, Parents' Rating Scale for Children, and Children's Behaviour Scale (from the Parent's Attitude Test: Cowen *et al.*, 1970).

Parent characteristics. Forehand used the Locke-Wallace Marriage Inventory to determine if there was any marital discord, as well as the Beck Inventory, which measures depression.

When does measurement occur? Forehand measured pre- and post-treatment, as well as two follow-ups at 6 and 12 months. This included questionnaires and home observation data.

Heifetz administered the Behaviour Vignettes Test pre- and post-training, while administering the attitude questionnaire post-training only. The major outcome measure of his study was the Behaviour Assessment Manual, which was administered pre- and post-training.

Eyberg and Johnson administered most of the outcome measures pre- and post-treatment. Parent observation data were collected on an ongoing basis.

Who is measuring? In early studies, data collection was either done exclusively by a therapist in a clinical setting or by the parent in the

home. Because of questionable reliability of one observer in one setting, Eyberg and Johnson (1974) recommended the use of multiple assessment. A number of studies in the 1970s (Forehand *et al.*, 1979; Heifetz, 1974, 1977; Patterson *et al.*, 1974, 1975, 1977) used such multiple assessments in an attempt to make their outcome data more reliable and valid. Usually, multiple assessments include observations by the parents, by trained observers, by the child, and/or audio-visual monitoring. Measurement of attitudes are usually recorded by questionnaires to be completed by the parents.

Methodological problems

Problems encountered in doing research in parent training include:

(a) the questionable accuracy of the data collected when a parent is being observed (Johnson & Katz, 1973); it is likely that the parent interacts with the child differently when observed;

(b) low reliability of a number of the measures used (Cobb & Medway, 1978);

(c) need for more control for therapist expectancy bias (Cobb & Medway, 1978);

(d) ethical issues surrounding:

(i) ABAB design in single case studies. This is normally avoided by the use of a multiple baseline design;

(ii) use of placebo or no-treatment. This is usually avoided by use of a waiting list or by later offering the optimal treatment situation to the parent;

(e) in order to control for confounding variables, it is necessary to have a large subject pool. This is not always feasible in a smaller community and when relying on volunteers who are seeking training.

Review of Parent Training with Developmentally Delayed Children

Training programs for parents of developmentally delayed children differ little from other parent-training programs with this exception: generally, parents of noncompliant children are learning to decrease negative behaviour and reinforce a more desirable alternative behaviour. Parents of developmentally delayed children are usually taught not only how to decrease negative behaviour, but also to teach new skills which the child has not yet learned. With more and more emphasis on early intervention and stimulation of handicapped children, parents are seen as the primary teachers of their young children. Instructional programming, then, becomes an important element in parent training.

Approaches

Parent training falls into two general categories. The first is via individual consultations, usually aimed at dealing with a target behaviour, e.g., toilet training (Foxx & Azrin, 1973; Heifetz, 1977), communication skills (Arnold *et al.*, 1977), self-help skills (Heifetz, 1977; Watson & Bassinger, 1974), social skills (Freeman & Thompson, 1973). The second is group training, aimed at (1) teaching behavioural principles, as well as specific skills (Benassi & Benassi, 1973; Berker *et al.*, 1976; Salzinger *et al.*, 1970); and (2) teaching parents to follow programmed instructions, or 'recipes' (Shearer & Shearer, 1972; Watson, 1973). There has been considerable criticism of this approach (Cunningham in Kiernan, 1975; Garth, 1979), as it is seen to leave the parent with little understanding of the underlying principles and consequently leaves the parent reliant on ongoing professional help. There is some question, however,

as to whether it is realistic to expect the parent to become expert in developing a variety of training programs (Cunningham in Kiernan, 1975). Perhaps a solution lies in devising a program which offers the best of both worlds: structured, developmentally sequenced tasks, as well as the underlying principles in order to afford the parent the ability to adapt the programs to fit the individual needs of the child.

Methodological problems

Subjects. There is no clear definition of developmental delay and many developmentally delayed children have other handicaps.

Relying on labels already given to the child is dangerous due to the variety of definitions and sources of the diagnosis. Heifetz (1974) avoided this dilemma by doing a functional assessment (Behaviour Achievement Manual) on each child pre- and post-treatment. However, the inclusion of other handicaps and confounding variables is virtually impossible to avoid, unless dealing with a very large subject pool.

Measurement. Because of the diversity of the abilities and disabilities of the children, pre- and post-treatment measures can only be compared within individual cases. Handicapped children learn at different rates, and a child who learns five tasks during treatment cannot necessarily be considered more successful than a child who achieves one task. Even if it were possible to select subjects who were on the same developmental level, there would be several potential confounding variables: the chronological ages would probably not be identical; the children may well have 'splinter skills,' i.e., be generally on one level developmentally,

but be able to perform individual, selected skills on a higher level.

Parents. If it were possible to select children who were developmentally and chronologically comparable, the chances of then finding within that group parents of similar sex, socioeconomic and educational backgrounds would again necessitate a very large subject pool.

Materials used. Many of the materials used are either geared for the noncompliant child alone (Becker, 1971; Patterson, 1977), require a high level of reading ability (Baker *et al.*, 1976), or have not been carefully assessed for effectiveness.

Size of sample. Because of the above-mentioned problems, the sample size is generally small, or studies limit themselves to single-case method.

Measures used. In parent training in general, as well as in training parents of handicapped children, there has been a lack of use of multiple measures in the past. It has been emphasized that multiple measures produce more reliable results (Cobb & Medway, 1978; Heifetz, 1974; O'Dell, 1974).

A review of the Heifetz study (1977)

The Heifetz study has been cited as a good example of a multiple-measure parent-training program (Bernal & North, 1978; Christensen *et al.*, 1980; Molloy, 1980). Because Heifetz deals specifically with developmentally delayed children, it seems appropriate to summarize his approach and findings.

Baker *et al.* (1976) developed a series of training manuals that offer information dealing with behaviour problems, self-help skills, play activities, and language skills. The manuals, used by Heifetz, in his study provide information regarding principles as well as exercises to be carried out by the parent.

Heifetz compared five groups: (1) manual only, (2) manual + phone contact, (3) manual + training groups, (4) manual + group + home visits, and (5) no-treatment control. The training period was 20 weeks. Children were grouped according to previous knowledge of behavioural techniques. They were then randomly assigned to the groups. There were 128 treatment families and 32 control families; these were selected from 160 families who expressed a desire to participate in the study after attending an introductory session.

The multiple measures used were discussed earlier and will not be repeated here, except to mention that parent knowledge and specific self-help skills acquired were both measured.

The results were as follows: there was no significant difference between the manual-only and the manual-plus group, while the manual-plus-phone condition was inferior to the other conditions. Heifetz notes that the manual-plus group parents expressed more confidence as teachers, while the manual-alone parents showed the greatest overall self-help gain. Heifetz speculates that the manual-plus-phone format fostered dependence on the consultant and resulted in the least amount of gain. He concludes that a combination of the manual-only and group approaches would be the best. He suggests group meetings at transitional points only.

The one major criticism of the Heifetz approach is the high reading ability needed in order to benefit from his manuals.

CHAPTER 3

CONCEPTUAL FRAMEWORK AND METHODOLOGY

Overview

Objectives

The objectives of the project were to develop a parent-training program which:

(a) would not rely on a manual or text,

(b) would teach parents:

(1) how to use task-analyzed materials for instructional programming with their children;

(2) the basic principles of social learning theory; and

(3) how to apply basic techniques in behaviour management and instructional programming.

Development of the videotapes

To achieve these objectives, a series of nine videotapes were developed. Specific objectives were delineated for skills and knowledge for parents to have obtained for each videotape and for the set of tapes as a whole. Each tape was based on information presented in the previous tapes, and was consequently not designed to be viewed in isolation from the others, but rather as a segment of ongoing instruction. This parallels Meyer's minicourse (1979). With individual instruction, however, it has been possible to use selected tapes to demonstrate a particular technique.

The tapes offered the following format:

(1) Instruction in lecture form. Following the example of programmed instruction, the tapes were designed to be periodically stopped and

parents were asked to answer questions on the information presented and its application to their own children. The questions were intended to determine if the parents understood the concepts presented and as a focal point for discussion. See Appendix H for sample answer sheets.

(2) Modelling of specific techniques to be practiced by the parents.

(3) Role-playing assignments to be performed during the session.

(4) Home assignments related to the information presented.

(5) Review of the home assignment in the subsequent session.

Videotapes were selected because they offer several advantages over other presentation media:

(1) A minimum of reading and writing is required; in fact, questions on the answer sheet could be answered orally if necessary.

(2) Video cassettes can be used by almost anyone with little danger of ruining the tape or machine. This facilitates a wider use of the tapes by both paraprofessionals and parents.

(3) Information can be reviewed easily by rewinding the tape.

(4) By having a 'pause' function on the machine, the tape may be stopped at any time in order to answer questions or accentuate a particular point.

(5) The tapes could be produced with a minimum of technical expertise and expense.

The parent-training course included nine sessions in which the parents were requested to select a skill to teach their child (based on the RADEA program or other task-analyzed materials) as well as a behaviour to change. See Appendix A for an outline of each individual tape (and availability for viewing) and Appendix B for a summary of the RADEA program.

Method

Subjects

A total of 39 families were initially contacted for training sessions. With one exception, all families had been referred to the Department of Psychology at the Izaak Walton Killam Hospital for Children for assessment and/or treatment. The one exception was referred directly by a pre-school teacher for the parent group in particular. Of the 39 families contacted, 22 chose not to participate in the parent groups for a variety of expressed reasons, ranging from lack of interest to transportation difficulties. Of those 22 families, two came for one initial interview, but did not attend subsequent sessions.

The Children. All of the children had been assessed as developmentally delayed. No exclusions were made based on age or handicaps of the child. The following table delineates the number of children with specific handicaps:

Language delay	14
Motor difficulties	8
Visual impairment	2
Hearing impairment	1
Autistic features	1

Twelve of the children had more than one handicap. During the initial interview, parents were asked to define the major problem that they would like to work on with their child. For the purpose of the study, the children were divided according to the parents' perceived focus of concern into two categories:

(1) Behaviour management. In this category, (a) parents mentioned as one of their major expectations of the course to learn behaviour management skills, or (b) when asked on the 'Behaviour Problems' section of the 'General Information' form (see Appendix B), "Is this a problem for you?", parents answered 'yes' to six or more behaviours.

(2) Skill acquisition. Parents in this category expressed their primary need as teaching their child new skills. Eleven families perceived behaviour management as their major concern, while only six attended the course primarily to learn skill acquisition.

Eight of the children were female and nine were male. Ages at the time the course began for each child ranged from 1 year, 6 months, to 9 years, 6 months, with a mean age of 5 years, 6 months, and a median of 6 years, 4 months.

The parents. Criteria for acceptance into the groups were:

(1) Referral to the Department of Psychology at the Izaak Walton Killam Hospital for Children for assessment and/or counselling for developmental delay (or related behavioural problems). One exception was made because of a last minute cancellation of another family.

(2) Agreement by the family that one member would come to all sessions (and would make up any tapes missed before the next session). Although monetary contingencies were not placed upon the parents, an initial interview was required, at which time a verbal commitment was elicited. It was hoped that this would decrease the likelihood of dropout.

There were a total of 27 parents, representing 17 families, who attended. Ten families were represented by both parents. Four were single

parents and the remaining three had only one of the two parents in attendance at the sessions. Sixteen of the participants were female, with eleven males. The number of years of education ranged from 6 to 18, with a mean of 12.7 and a median of 12 years. The educational level of one parent is unknown. None of the parents had attended a similar parent course. However, ten of the families had some previous instruction in skill acquisition and five had some instruction in behaviour management. Most of the instruction had been individual and specific to a particular problem. Sources of information included teachers, therapists (occupational therapists, physiotherapists, and speech therapists), and psychologists. Fourteen of the families came from the greater Halifax area; three commuted from out-of-town and from as far away as 60 miles.

Therapists

All of the sessions were conducted by the same two therapists, the Director of the Behaviour Therapy Clinic at the Izaak Walton Killam Hospital for Children and a Master's student at Saint Mary's University in Halifax, Nova Scotia. Both instructors (one female and one male) had well over 5 years experience in using behavioural techniques with handicapped individuals, and both had conducted previous parent-training groups. Both individuals were directly involved in the production of the videotapes that were used in the course.

Dependent measures

Parent's knowledge of the principles. A test of 25 questions combined items from the Heifetz study (1974) and items specific to the

videotapes (see Appendix H). Concepts covered included theory, selecting a behaviour, teaching a skill, reinforcement, negative behaviour, and recording. Results were analyzed in terms of (a) individual and group improvement in scores, and (b) group performance on specific principles. Both tests were identical, but questions were arranged in a different order. Test 1 was given at the beginning of Session 1 and Test 2 was given at the end of Session 9.

Parents were videotaped while they taught their child a skill in a clinical setting. Scores were given in terms of percent of correct responses. Topics evaluated included: (a) setting up the environment; (b) giving instruction; (c) waiting for a response; (d) ignoring or giving assistance (given no response); (e) reinforcement; and (f) ending the session. See Appendix H for the evaluation form used.

A telephone interview was conducted by the author one month after the last session and parents were scored on: (1) follow-through of skills taught during the course; (2) follow-through of the behaviour program initiated during the course; (3) generalization of the principles to (a) other behaviours, and (b) other siblings; and (4) appropriate application of the principles taught. This was scored as percent correct out of a total of 13 possible points. See Appendix H for the evaluation form used.

Child's performance. Progress was recorded in terms of the number of tasks completed from either the RADEA program or other task-analyzed materials (in particular, Anderson *et al.*, 1972) and the number of steps within tasks completed. Both RADEA and the Anderson book give mastery

criteria for completion of a task and step. This was recorded at the end of the course, at a one-month follow-up, and at a two-month follow-up (for the first nine families, as the other families had not been out of session for two months at the time of the data analysis). It was also recorded whether the parents continued to work on a skill at those intervals, and whether they were teaching a skill to other siblings.

Behaviour change was also recorded at the three time intervals. Results were recorded in terms of: (1) whether the family was working on a behaviour program (i.e., the parents had identified a specific behaviour to change and were approaching the problem in a consistent manner, using behavioural principles); (2) the direction of the behaviour change (i.e., better, same, or worse); (3) generalization to other behaviours and to siblings; and (4) whether the behaviour chosen during the course remained a problem to the family.

Evaluations by the parents

Overall evaluation of the program. The videotapes were a pilot project. It was hoped that preliminary use of them would highlight strengths and reveal problems needing improvement. Consequently, parent evaluations were a vital measure of the success of the course. Parents were requested to sign their evaluation because it was important to define which types of children and parents benefited the most from the course. This procedure made it difficult to elicit candid evaluations; one would expect that there would be a trend to answer in a socially acceptable manner. See Appendix H for the overall evaluation form.

Evaluations of individual sessions. Parents completed an evaluation form after each session. This measure provided an evaluation of individual sessions in terms of interest, appropriateness, and clarity. See Appendix H for the forms used.

Dropout. In order to determine reasons for dropout, a form which the parents were not required to sign was sent to all parents who dropped out. This included a self-addressed, stamped envelope which was coded in order to determine those parents responding. Appendix I contains a copy of the letter used.

Treatment specifications

A total of nine videotapes were developed, as described previously. The concepts and skills to be taught were carefully delineated for each session, and the scripts, answer sheets, and home assignments were then designed to teach those specific areas. By using a programmed instruction format, it was anticipated that parents would get immediate feedback as to accuracy of their knowledge; in addition, a note book was provided for parents so they could consolidate the information as a manual for future reference.

Each of the 39 original families was contacted by telephone. The purpose, format, and general expectations of the program were explained to them, and if the parents then expressed interest in participating, an appointment was made for an interview. Twenty-two appointments were made, nineteen were interviewed, and seventeen participated as a follow-up to the interview. The interview consisted of a more detailed description of the program (including an outline which was given to each parent),

a discussion of the expectations of both the parents and the therapists, and completion of the 'General Information' form. A verbal contract was elicited from each family.

The first session consisted of introduction, the Test 1, and Videotape 1. Parents were encouraged to ask questions at any time and to discuss their children and approaches that had worked for them. Each session lasted about two hours, ended with a home assignment and an evaluation of the session, and frequently continued informally for a few minutes beyond the official end of the session.

A second test and overall evaluation were given on the last night of the course. One-month and two-month follow-ups were conducted by telephone by the therapists, following the format of the 'Standardized Interview' form. At the completion of the course, parents were requested to bring their children to the clinic for videotaping and evaluation of their teaching skills. Parents were asked to teach the skill they had been working on at home. Suggestions were made either verbally or via modelling and the parents then worked with their child making adjustments according to the suggestions. Scores of percent correct were obtained for the entire session, including performance before and after suggestions were made.

A follow-up session was offered to each parent one month following the end of the course. Ten of the twelve families attended this meeting. The topic chosen by the parents was toilet training. It was explained to those parents that it would be their responsibility to make contact individually for suggestions for behaviour management or further tasks to be taught. Parents were encouraged to do so at any time without hesitation.

Design

The data were analyzed in three major areas: parent's knowledge of the principles; child's performance; and evaluations by the parents.

Parent's knowledge of the principles. The same test was given on the first and last sessions. A *t*-test (two-tailed, for dependent samples, df = 16) was used to evaluate the differences in scores (recorded as percent correct). In addition, mean scores on six major concepts in the second test were calculated.

Scores in six concept areas were recorded in terms of percent of correct responses.

Interviews were divided into four concept areas, with a total of 13 possible points. Scores were reported as percent correct at three time intervals. Tests 1 and 2, videotaped performance and standardized interview scores were then statistically analyzed for correlations.

Child's performance. The child's skill development was reported in terms of tasks and steps completed during the three time intervals. Their behaviour change was reported as percent of parents working on a behaviour program, reporting direction of change, and generalizability at three time intervals.

Evaluations by the parents. Overall and individual session evaluations were reported in terms of number responding to a given question. Most frequent or outstanding comments were reported in the data analysis section, but all comments may be found in Appendix E, Tables 6 and 7.

Limitations. Before proceeding with a discussion of results, there are a number of limitations to the experimental design which should be taken into account.

(1) Lack of a homogeneous sample. There are two major reasons for this limitation: (i) Halifax is a small city with a limited population of developmentally delayed children; the Izaak Walton Killam Hospital for Children further diminished the number of potential subjects by requesting that the sample be limited to children already referred to the hospital; and (ii) there is a certain amount of ambiguity concerning the definition of developmental delay. The children referred for assessment or treatment to the hospital vary widely in types and numbers of handicaps as well as in abilities.

(2) Lack of a control group. The reason for this serious drawback in the study stemmed from the difficulties in recruitment. Although a waiting list control would have been ideal, it was felt that administering a test months in advance of the course might be so aversive as to eliminate a number of parents from future sessions. This would be particularly true for parents with limited education, a group for whom the tapes were specially designed. A placebo group was not considered due to the ethical responsibility to offer the best service possible to clients.

(3) Lack of a baseline on performance skills. Observation at the hospital on their first appointment suggests that most parents are quite unsure of their abilities to manage and/or teach their child. To videotape them working with their child without feedback or suggestions at such a vulnerable time could be very threatening, and might eliminate parents from future sessions. It cannot be overemphasized that the primary objective of the hospital is to provide a service to the individual child and family, and

this must take precedence over procedures which would have made this study more rigorous.

(4) Use of parent report for information on tasks and behaviours achieved. Parents are frequently inconsistent in their recording (O'Dell *et al.*, 1977). However, by including the videotaped performance and the written test, it was intended that the more objective reports could be combined with parent reports to determine the progress of both parents and their children.

(5) Requesting parents to sign their evaluations made them more likely to answer in socially acceptable ways. In spite of this drawback, it was necessary to know which parents benefited the most and whether there was any correlation between type of child or educational background and satisfaction with the course.

CHAPTER 4

RESULTS

Parent's Knowledge

Tests 1 and 2

Each parent was given a test on the first and last sessions that consisted of 25 questions covering the following concepts: theory, selecting a behaviour, teaching a skill, reinforcement, negative behaviour, and recording. Three of the 21 parents completing the course took only one of the two tests and were consequently eliminated from the analysis of the two tests.

The results of the tests and average change scores are as follows (see Table 4 of Appendix E for a detailed breakdown):

N = 18	Test 1	Test 2	Change Score
Mean	45.7%	70.45%	+28.2%*
Median	46	72.5	+28.5
Range	18-72	40-92	-13 to +58
Standard deviation	14.8	13	

* $p < 0.01$, two-tailed; $df = 16$; $t = 6.98$.

As may be noted from the above table, one individual dropped 13 percentage points (or 3.2 questions) from Test 1 to Test 2. It is not at all clear why this occurred, although there are two factors which may have contributed to this result: (1) the individual attended only six of the nine sessions, and relied on his spouse to relay material he had missed; and (2) the parents were attending another lecture series using

a different approach to behaviour management, and expressed some confusion as to approaches.

An analysis of the six concepts covered in Test 2 yielded the following means: Theory = 60.5%; Selecting a Behaviour = 53.3%; Teaching a Skill = 83.4%; Reinforcement = 69.5%; Negative Behaviour = 67.5%; Recording = 89.2%; Total = 70.45%. From this breakdown, one must conclude that the parents scored highest on Recording and lowest on Selecting a Behaviour. Table 5 in Appendix E shows the results in more detail.

Videotaped performance

At the initial interview, parents agreed to bring their child into the hospital in order to work with their child under supervision. However, only seven of the twelve families actually were videotaped. Each parent was asked to teach his/her child the skill chosen during the course. The session was videotaped, suggestions were made to the parents, and an additional session was videotaped after suggestions were made. The tapes were scored in six areas: (1) setting up the environment; (2) giving instruction; (3) waiting for a response; (4) if no response, (a) ignores, (b) gives assistance; (4) reinforcement; and (6) ending the session. Scores were given in terms of percent of correct responses.

The results of the seven scores obtained were as follows: Mean = 86.2%; Median = 92%; Range = 48.6 to 100%. Most errors in the sessions related to: (1) waiting for a response (i.e., parent did not wait at least 5 seconds before ignoring or giving assistance); and (2) ignoring (i.e., ignores at least 5 seconds, with no eye contact and no verbal contact). Reinforcement, giving instruction, and giving assistance were

consistently good; all parents set up the environment appropriately and ended the session on a success.

Standardized interview

Each family was contacted by telephone for an interview in order to assess: (1) follow-through of skills taught during the course; (2) follow-through of behaviour program taught during the course; (3) generalization of the principles to (a) other behaviours, and (b) other siblings; and (4) appropriate application of the principles taught (i.e., setting up the environment, giving assistance, reinforcement, dealing with negative behaviour, and recording). A total of 13 points was possible, with the score recorded as percent correct.

Overall scores were: Mean = 61%; Median = 73.5%; and Range = 11 to 100. Specific findings were as follows:

	End of Course (n=12)	1-month follow-up (n=12)	2-month follow-up (n=8)
Still working on a task	91.66%	91.66%	62.5%
Still working on a behaviour program	92%	92	62.5
Generalization of the principles to other behaviours		75	
Generalization of the principles to siblings:			
- behaviour management		42.9	
- skill training		14.3	
- not applicable		41.6	

While most parents were recording progress at the end of the course, only 25% (n=12) were still recording one month later. Other principles

were generally applied appropriately. Two families neglected to select a positive alternative when working on a negative behaviour. It should be noted that these findings reflect the parents' report of what they are doing with their child. The two-month follow-up includes only the first eight families (excluding the one dropout) as the above data were collected before a two-month follow-up was possible for the remaining families.

Correlation of Test 2 scores, videotaped performance scores, and standardized interview scores

Pearson Correlation Coefficients were calculated (n=7) between Test 2 and the Standardized Interview (r=0.13), Test 2 and Videotaped Performance (r=-0.26), and the Standardized Interview and Videotaped Performance (r=-0.12). In all three instances, the correlations were statistically nonsignificant.

Child's Performance

Skill development

During the course, each family selected one skill to teach its child. Most families used the RADEA program, although other task-analyzed materials were available and were selected by two families. Once a task was selected, the families were given a copy of a task analysis for the task selected. The number of steps within the tasks selected ranged from 2 to 28, depending on the complexity of the task and the degree of analysis. Because of the wide age- and ability-range of the children, it would serve little purpose to compare individual scores. However, because RADEA is organized developmentally and tasks were chosen according to the individual

child's needs, it was possible to observe progress in all of the children. Only one child failed to complete a task. The parents reported that his behaviour problems prevented them from working on a skill. Of the remaining eleven children, the number of tasks completed at the one-month follow-up ranged from 1 to 5, with a mean of 2.27 and a median of 2; the number of steps within the task completed at the one-month follow-up ranged from 4 to 17, with a mean of 9.36 and a median of 11. At the two-month follow-up, four of the eight children had completed an additional task, with the total number of steps achieved ranging from 3 to 26. Of the four not achieving further tasks at the two-month follow-up, three of the families were no longer working on teaching a new skill. See Table 2 for details of these findings.

Behaviour change

In addition to skill training, families selected a behaviour problem they hoped to improve. A number of the families were in a hurry to begin behaviour management at the outset of the course. However, with two exceptions, the families acknowledged that they had a better understanding of the principles by working on a skill first. It is interesting to note that the two who were dissatisfied with the inclusion of instructional programming both had higher functioning, older children, and showed the least amount of overall progress in both skill achievement and behaviour management.

At the end of the course, 92% were working on decreasing a negative behaviour. The behaviour they had chosen to improve was still a problem to 75%. Nevertheless, 75% reported the behaviour had improved and 25%

reported the behaviour was the same.

At the one-month follow-up, 92% were working on a behaviour program. Of the 75% who still considered the behaviour a problem at the end of the course, all reported the behaviour continued to be a problem; however, 33.3% reported further improvement, while 66.6% reported the behaviour had remained the same since the end of the course.

At two-month follow-up, 62.5% of the eight remaining families were still working on a behaviour program. Four of the eight no longer considered the originally selected behaviour a problem. Of the remaining families, one reported the behaviour had improved further, three reported it was the same, and one reported it was worse. In one family, the parents reported that while the behaviour remained the same, they no longer considered the behaviour a problem.

Evaluations by the Parents

Overall evaluation of the program

Each parent was asked to evaluate the program as a whole on the last night of the course. Evaluations were generally favourable in terms of number and length of sessions. Seven people would have preferred more sessions on behaviour management. In spite of the diversity of handicaps exhibited by the children in the groups, eleven parents considered the program very appropriate to their child, two rated the program quite appropriate, and seven rated it acceptable. Parents were satisfied with the amount of time devoted to their family and to informal conversation during meetings. In response to the question, "Did the program satisfy your expectations?", nine responded "acceptable." All parents considered the

overall program either "very helpful" or "quite helpful." The behaviour management segment was rated slightly higher than the instructional programming section in terms of helpfulness. Method of material presentation was generally satisfactory, with eight people preferring more demonstrations, and five each preferring more discussions and examples. Eight parents felt that there had been a positive change in their attitude, while ten reported no change in their attitude. All parents agreed that other parents of exceptional children could benefit from a similar course.

When asked what was most helpful about the sessions, the following responses were made (in order from most to least frequent response): sessions on behaviour management (10); more awareness of parent's own behaviour (7); sessions on instructional programming (5); support and ideas from other parents (5); home assignments (4); examples and demonstrations on videotapes (4); group discussion (3); good instructors (1).

Suggestions for change included: written text to accompany the videotapes (4); shorter sessions (2); more examples (2); a list of references to accompany videotapes (1); and elimination of programmed instruction approach (e.g., "Stop the tape and answer question number ---"). See Table 6 for a detailed analysis of the evaluations.

Evaluations of individual sessions

At the end of each session, parents were asked to evaluate the individual sessions, with the following results:

Length of session. Most sessions were rated as "about right"; Sessions 1 and 5 were considered slightly too long by 7 and 6 parents, respectively. Sessions 7, 8, and 9 were rated too long by a small number of parents.

Clarity of instruction. Instruction ratings ranged from "acceptable"

to "very clear" on all sessions.

Demonstrations

Usefulness. With the exception of one rating of "of little use" on Session 1, all ratings ranged from "acceptable" to "very helpful."

Clarity. Individuals found Sessions 5, 7, and 9 confusing. All other ratings ranged from "acceptable" to "very clear."

Content

The content was generally considered "about right"; three parents found Session 4 "slightly too simple"; and individuals found Sessions 1, 2, 5, 8, and 9 slightly too complicated.

Amount of information covered

Ratings were generally "about right"; however, with the exception of Session 9, between one (Session 5) and five (Session 1) parents found the information covered to be slightly too little.

Level of interest

All ratings ranged from "acceptable" to "very interesting." Sessions rated as very interesting by 10 or more parents included Sessions 1, 3, 7, 8, and 9.

Questions on answer sheet

Clarity. Most sessions were rated "acceptable" to "very clear," with Sessions 1, 7, and 8 receiving the highest ratings. Four parents

found the questions in Session 1 to be "not very clear" or "confusing." This may have been because it was the first session and the parents were not yet familiar with the format.

Amount. Most ratings were "about right." However, with the exception of Sessions 1, 6, and 9, between 1 and 3 parents felt there could have been more questions.

Home assignment

Clarity. Ratings generally ranged from "acceptable" to "very clear." Sessions 1, 3, and 6 received the highest ratings.

Amount. Ratings were almost exclusively "about right," with individuals finding the assignments too little.

Appropriateness of this material for your child

Most appropriate sessions were Sessions 7, 8, and 9 (with 11, 11, and 10 parents, respectively, rating them as "very appropriate"); other sesssions receiving high ratings were Sessions 1, 3, and 6. Individual parents found Sessions 1, 2, 8, and 9 "quite inappropriate."

Suggestions for improvement

Most frequent comments were: (1) want more management skills (5), and (2) better quality of the videotapes (3).

In summary, Sessions 7, 8, and 9, which dealt with behaviour management, were given the highest ratings in terms of interest and appropriateness for the child. Sessions 1 and 3 were next highest in overall ratings,

including appropriateness, level of interest, and overall clarity. These two sessions discussed instructional programming.

Dropout

Dropout is of concern because it may indicate dissatisfaction with the program or lack of commitment. For this reason, a questionnaire that did not require the parent's signature was sent to all families who did not complete the course. The questionnaire asked for reasons for discontinuing the course, as well as for possible changes which would have made the group more appealing to the family (see Appendix I for a copy of the questionnaire).

Of the 17 families who were interviewed initially and attended the first session, 5 families dropped out. One family attended two sessions, while the remainder attended only the first session. The mean age of the children was 6 years, 5 months, as compared to the mean of 5 years, 1 month, in those families completing the course. The ages of the children of the dropouts was 5 years, 0 months, to 8 years, 5 months. Years of education were slightly lower in the dropout group, with a mean of 11.3 (range = 6-16), compared to those completing the course (mean = 13.1; range = 9-18). Pretest scores were also slightly lower (dropout mean = 40; range = 14-76) than those completing the course (mean = 45.7; range = 18-72). Eighty percent of the dropouts considered the primary concern regarding their child to be one of behaviour; 58% of the parents completing the course considered behaviour to be their primary concern (see Table 8 in Appendix E for details).

Only two of the five families contacted completed the questionnaire.

One parent stated that she no longer had custody of her child. The second response also indicated the child no longer lived at home, and had been placed in a residential facility. This particular family had attended the second session of a previous parent group and had dropped out because they felt the group was inappropriate for their child. It is interesting to note that among their comments is expressed the concern that the techniques would not work for their child and that psychologists offer suggestions that require ideal conditions not easily adaptable to the home environment.

Of the other parents who did not answer the questionnaire, one had shown interest in a previous group, but decided not to attend due to her husband's opposition. Another parent mentioned in the initial interview that she had dropped out of a parent support group because she felt shy with groups of people. (This parent was offered individual training sessions later.) The third family consisted of a couple who were also receiving individual counselling for behaviour problems with their child, and mentioned in the first two sessions that they did not see a similarity between their child and the examples used on the tapes. These parents had limited education and would qualify as functional illiterates.

It is impossible to draw any firm conclusions due to the small sample size. However, it would appear that reasons for dropout were individual and probably could not have been predicted. Three of the families expressed some ambivalence about parent groups before the group began. It is unfortunate that all parents did not respond to the questionnaire, leaving us to speculate as to cause of dropout. In particular, the elderly couple with limited education could have given valuable information regarding the clarity of the videotapes for individuals who are functional illiterates.

CHAPTER 5

DISCUSSION

Objectives

The previously stated objectives of this project were to develop a "parent-training program which:

(a) would not rely on a manual or text; and

(b) would teach parents:

(1) how to use task-analyzed materials for ihstructional programming with their children;

(2) the basic principles of social learning theory; and

(3) how to apply basic techniques in behaviour management and instructional programming" (p. 27 this text).

Although a certain level of reading and writing skills were required in order to complete Tests 1 and 2 and questions on the answer sheet, the first objective was achieved by the development of nine videotapes. Within certain limitations which will be discussed in depth in the following sections, parents demonstrated an ability to use task-analyzed materials, behaviour management, and instructional programming techniques. When drawing conclusions, some of the points made below should be kept in mind, particularly in considering possible adaptations.

Implications of Limitations to the Study

Five limitations were mentioned in the design section of the method. The implications of each are discussed below.

Lack of a homogeneous sample

Because of the variety of ages and handicap severity of the children and the range of educational levels and previous experience of the parents, it is difficult to decide who benefited most from the tapes. The children were of different abilities and developmental levels, making it difficult to compare one child to another. Use of task-analyzed materials and evaluation of the parents' ability to use the techniques made this problem a smaller obstacle. Probably the most unfortunate effect of this limitation was that the educational level of the parents was higher than would have been ideal. This will be discussed in more detail in a later section.

Lack of a control group

Although one can argue that lack of controls reduces the certainty that the achieved progress was attributable to the training sessions, the type of course that was being conducted should be considered. By setting specific objectives and teaching the parents to criterion, the primary focus was on determining if they had indeed learned those pinpointed concepts or skills. By the use of several measures, the credibility of conjectured spontaneous improvement in all areas is diminished.

Lack of baseline on performance skills

Again, taken in isolation this limitation might call into question whether there was indeed improvement. Although a baseline videotape would have been ideal, the objective required parents to perform the designated skills by the end of the course. The fact that only 7 of the 12 families actually brought their children to the clinic to be videotaped

indicates that there would probably have been difficulty in bringing them in for an initial taping session. Perhaps this information could be obtained either informally in the home or several videotape sessions could be arranged at set intervals after the parents have attended one or two sessions and are more comfortable.

Use of parent report for information on tasks and behaviours achieved

One must be guarded in interpreting the parents' reports of tasks achieved and negative behaviours eliminated, because of a tendency to give socially acceptable responses. The use of the videotaped performance session eliminated this problem for seven of the families by allowing the group leaders to observe their progress first-hand.

Requesting parents to sign their evaluations made them more likely to answer in socially acceptable ways

Results showed a tendency to answer in a neutral or positive manner. In spite of this tendency, a number of parents gave quite candid suggestions for improvement. In future groups, it might be worthwhile to code the forms so that the parents believe their answers are anonymous, but in such a way that the therapist could determine which parents are satisfied with particular tapes and with the course as a whole.

Parents' Knowledge

There was a significant improvement from Test 1 to Test 2 scores. Because of the educational level of the original 27 subjects (mean = 12.7),

it is difficult to draw conclusions regarding the effectiveness of these tapes for parents with limited education. The two parents who would qualify as functional illiterates (one with Grade 6 and one with Grade 7 education) dropped out after the second session, and did not answer the questionnaire asking for their reasons for dropping out. Two parents who completed the course had only a Grade 9 education. One achieved a change score of +14 (42-56%), 75% on the Standardized Interview, and 100% on the Videotaped Performance. The second parent received a change score of +24 (48-72%) on the written test, 11% on the Interview, and 100% on the Videotape. A parent with a Grade 10 education received a change score of +49 (29-78%) on the test, and 90% on the Interview. One parent received a change score of -13 (57-44%) on the written test; however, there is no information regarding his level of education. All other parents had a Grade 11 or higher.

In the future, it would be interesting to obtain data from parents with less education. In addition, data on socio-economic status were not collected for this group and would be worth looking at in future studies. Before these videotapes are revised, it is recommended that the final script, as well as all written tests and answer sheets, be evaluated using Flesch's readability yardstick.

The small number of subjects necessitates caution in drawing conclusions in general, a caveat underscored by the low intercorrelations found among Test 2, the Standardized Interview, and the Videotaped Performance. It is interesting to note that the parent with the most education, who found the programmed instruction format too slow and wanted more information in several of the sessions, showed the lowest score on the Videotaped Performance. On the other hand, a parent with a lower

education who did poorly on the written test performed excellently on the Videotaped Performance. Another parent did well on the test and Videotaped Performance but failed to follow through once the program was complete, thus doing poorly on the Interview. It is logical, therefore, to conclude that good test results do not necessarily imply that the parents will follow through upon completion of the course, nor that they will use their knowledge skilfully with their child in a hands-on situation.

Another limitation in the study was the measures that were not fully standardized. Most of the test items were derived from the Heifetz study, which *was* standardized. However, the manuals used in that study were at the Grade 13 reading level. In general, the measures were criterion-referenced, i.e., they referred to specific ideas or techniques taught in the course, and were not designed to test generalization.

Although an unbiased observer would have been ideal in order to remove therapist bias when measuring, it may have been quite threatening to the parents who were anxious about being videotaped even though they felt quite comfortable with the therapists.

Child's Performance

By the end of the course, all but one child had achieved at least one task. While it can be argued that this may be due to the passage of time, it is quite unlikely, as the parents chose a specific task based on the RADEA program and worked on the task daily for about 10 minutes. Because the tasks were analyzed into steps with one step taught at a time, it was possible to monitor exactly which step was being used and how it was being taught. While a waiting-list control group could have eliminated

most questions regarding effects not due to experimental manipulation, logistics made it impossible, and because the tasks were specifically identified during the course, it would have been difficult to measure how the control children had progressed.

A problem encountered by the therapists was one of recording. Parents continued to be reluctant to record both during the course and after it ended. It was consequently difficult to get accurate data, particularly on behaviour programs. Simplified forms should be investigated. The Videotaped Performance helped to get an accurate assessment of how the child was doing; perhaps this should be expanded to set intervals throughout the course and as follow-up. In addition, home visits and/or clinical sessions where a behaviour problem can be simulated might give the therapist the opportunity to observe, collect data, and model appropriate behaviour.

The question of generalization remains problematic not only in this study but in most other studies of this kind (Forehand *et al.*, 1977). Home observations and longitudinal follow-up seem to be essential for increasing the likelihood of generalization.

Generalization is closely tied to the problem of post-course follow-through on the part of the parents, which steadily decreased (in percentage) with each follow-up. It may be that the parents are unable to generalize their knowledge from one behaviour to another or to a skill that is not written on the RADEA cards. On the other hand, our evaluations may not be sensitive to true generalization, i.e., the parents may be applying the principles, but in a less formal, structured way, with positive results nonetheless. To set aside a structured time, to record, or

to write behavioural objectives may be too didactic for most parents. It might be worth investigating ways of teaching parents to make that transition from the structure of a course to the everyday 'snap' decisions required of parents in their own home. Other possible ways of keeping the ideas and approaches alive might be: (1) to conduct periodic follow-up sessions, where individual problems could be discussed, or the parents could choose a topic of common interest; (2) continued follow-up by appointment or telephone at the therapist's initiative; (3) a continuation of the parent group beyond the 9 weeks, with the therapist being faded out and the sessions serving more a function of sharing ideas and problems--perhaps with the option of inviting the therapist back to discuss specific topics; (4) a second 'refresher course,' perhaps with a greater emphasis on behaviour management; and (5) availability of the videotapes in the community or in the parent's own home for review or for exposure to new ideas more specific to their child.

Evaluations of the Tapes

Overall

Parents expressed a special concern for more information on behaviour management. This is somewhat problematic, as parents tend to want immediate solutions to complex problems. If behaviour management is taught too early in the course, there is the danger that the parents may drop out having learned only superficially how to eliminate a negative behaviour without looking at a positive alternative behaviour. It is likely that some parents tolerated the instructional programming segment in order to get to the behaviour management. Informally, several parents observed

that it was only in retrospect that they truly saw how vital the instructional programming part had been in teaching them to look at the positive. Nonetheless, there are a few modifications which could give the parents a sense of satisfaction earlier in the course. By giving some simple techniques of what to do when the child refuses to cooperate in the teaching session, the parents would have a taste of what is to come and this would help those parents whose primary concern is management. A few parents had difficulty teaching a task because they could not induce their child to participate.

An increase in demonstrations, both on the videotapes and *in vivo* would be an improvement suggested by several parents. Again the possibility of observation, modelling, and feedback in the home, as implemented by Patterson (1979) and Forehand (1977) might facilitate generalization. More demonstrations are particularly needed for the behaviour management section of the course.

Sessions 1, 5, and 9 were considered too long by several parents. By expanding the number of sessions by two or three, it would be possible to keep the sessions shorter, allow more time for discussion of problems specific to individual families and introduce more behaviour management skills into the instructional programming segment.

Other improvements would include a written manual with answers to the questions and references which could be purchased by the parents if so desired, an instructor's manual which could be distributed to paraprofessionals or professionals from other disciplines so that they can use the tapes in their own community, and improved answer sheets which, when completed, combine to give a clear outline of the information covered.

Individual sessions

Appendix F gives specific suggestions for each session. Most suggestions concern details which would make the tapes either technically or conceptually clearer. The two major changes suggested in format concern expansion of Session 4 to include management of the child who refuses to participate, inclusion of an additional home assignment in Session 6, and expansion of Session 9.

It is hoped that these tapes might also be expanded to include individual modules on specific techniques and/or problems. Some examples might be how to use a star chart, basic nonverbal communication, infant stimulation, setting up a token economy, information on specific handicaps and behaviour problems.

Dropout

Because of the small number of subjects, it is difficult to draw conclusions. Nonetheless, there was a 29% dropout rate. In future courses, it would be worth considering the use of monetary contingencies.

Cost Efficiency

The following is a rough estimate of therapist time devoted to the running of the two courses:

Item	Individual Time	Total Time
Initial phone contact	1 hr each x 39	39
Interviews	1 hr each x 19	19
Actual course time	18 hr each x 2	36
Video session	1 hr each x 7	7
Phone follow-up in first month	2 hr each x 12	24
		125

125/12 families = 10.4 hr per family

In order to give the course for 12 families, a total of at least 10.4 hours was expended. Much of that time involved initial phone contacts. In addition, with a group of eight or more families it is preferable to use two therapists, although not absolutely necessary.

There are several other ways that the tapes could be used with smaller groups which, in the long run, might prove to be more or equally as cost-efficient as larger groups which take a great deal of organizational time. By grouping two or three parents together as referrals are made, or by leaving the responsibility of finding a group of two or three parents to the parents themselves, it might be possible to greatly diminish the time consumed by recruiting parents for a group. With the use of a manual, it might be possible to leave the parents with the tape and questions and review any questions or problems at the end of the session with the therapist. This would mean a combination of independent study and periodic monitoring by the therapist, an approach suggested by Heifetz (1977). Specific to the Halifax locale, through the use of the Care-by-Parent Unit at the Izaak Walton Killam Hospital, it might be possible to bring two or three families from outlying areas for a week of intensive training using the tapes. The following are estimates of the time needed per person for groups of one, two, and three families, with initial recruitment time minimized:

	1 family	2 families	3 families
Interview	1	2	3
Actual course time	18	18	18
Video session	1	1	1
Phone follow-up/1 month	2	2	2
Total	22	24/2 =	27/3 =
		12 hr/family	9 hr/family

A small group of this size could easily be run by one therapist, and, if the tapes were viewed independently with the therapist participating only in the last hour of the group, the number of hours devoted per family could be further reduced to 13, 7, and 5 hours, respectively.

General Conclusions

The nine videotapes yielded favourable results. They certainly warrant further streamlining and adaptation. It would be ideal if ongoing data could be kept regarding those parents currently using them, as well as follow-up data on those parents who participated in the study. Future examination of the tapes might consider:

1. the usefulness of these tapes for parents with limited education compared to traditional material,
2. effectiveness of the tapes in relation to size of group,
3. independent study versus partial professional instruction versus total professional instruction, and
4. modes of ensuring optimal generalization.

It is hoped that this preliminary study will mark the beginning of the development of an effective training program which can be used throughout the province.

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APPENDIX A

OUTLINE OF THE VIDEOTAPES

I. THE EXCEPTIONAL CHILD

A. Introduction to the program and teaching methods in the program.

B. Problems with labels.

C. Normal child growth and development.

D. Growth and development of the exceptional child.

E. What can we do about it?

II. INSTRUCTIONAL PROGRAMMING: PART A

A. Task analysis.

B. Assessment.

III. INSTRUCTIONAL PROGRAMMING: PART B

A. Setting up the environment.

B. Getting the child's attention.

C. Giving instruction.

D. Waiting for a response.

IV. INSTRUCTIONAL PROGRAMMING: PART B (CONT.)

A. Helping the child to give a response.

B. Levels of prompts.

V. INSTRUCTIONAL PROGRAMMING: PART B (CONT.)

A. Reinforcement.

1. Selecting a reinforcer.

2. Giving reinforcement.

B. Recording.

C. Deciding when to move on to the next step.

VI. MANAGING BEHAVIOUR: PART A

A. Film: "Child's Behaviour Equals You".

B. The A-B-C's of behaviour.

VII. MANAGING BEHAVIOUR: PART B

A. Precisely describing behaviour.

B. Selecting a behaviour to change.

C. Two methods of recording a behaviour.

VIII. MANAGING BEHAVIOUR: PART C

A. Techniques for increasing positive behaviour.

B. Techniques for decreasing negative behaviour.

IX. MANAGING BEHAVIOUR: PART D

A. Arranging positive consequences.

B. Arranging negative consequences.

C. Stating rules.

Arrangements may be made to view the above videotapes by contacting the Psychology Department at the Izaak Walton Killam Hospital for Children in Halifax, Nova Scotia.

APPENDIX B

THE RADEA PROGRAM: A SUMMARY

The RADEA Program is a commercially-produced curriculum (published by Melton Peninsula Inc., 1978) designed to task analyze a variety of developmental skills and offer step-by-step instruction in how to select, teach, and record a given skill. Skills are organized in a developmental sequence based on Piaget's theory of child development. The program is divided into six areas: Visual Perception, Auditory Perception, Oral Language, Perceptual Motor, Functional Living, and Special Problems. Each area is divided into four levels: Level I is equivalent to 0 to 2 years developmentally; Level II is equivalent to 2 to 3½ years; Level III is equivalent to 3½ to 5 years; and Level IV is equivalent to 5 to 7 years. The program was developed by a team consisting of a special educator, speech pathologist, psychologist, and educational diagnostician. Skills were selected on the basis of an analysis of the major developmental milestones needed by students in a developmental population which included "approximately 450 severely and profoundly mentally retarded students who had accompanying disabilities" (from a letter from the publisher). The curriculum was evaluated over a 6-month period and was used with a population of 70 multihandicapped children ranging in age from 3 to 14 years, and described as "severely mentally retarded."

APPENDIX C

ILLITERACY FIGURES FOR CANADA AND THE MARITIMES

(BASED ON THE 1971 CENSUS)

	Total 15 years and over and not attending school	Total qualifying as functionally illiterate	Percent of population
Canada	13,168,020	4,574,130	34.74%
Nova Scotia	470;080	158,700	33.76
New Brunswick	366,875	164,050	44.72
Newfoundland	280,870	134,600	47.92
Prince Edward Island	65,135	26,105	40.08

APPENDIX D

DEFINITION OF TERMS

Behaviour Management. The implementation of principles of social learning theory (Patterson, 1977) to change observable behaviours.

Developmental Delay. American Association on Mental Deficiency defines mental retardation as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period." Because of controversy regarding classifying children by I.Q. scores and the dangers inherent in such labelling, "developmental delay" refers to a delay in one or several areas of development in relation to the norm for a child of any particular age.

Dropout. Any individual who attended the first session of a parent group, but did not complete the course.

Exceptional Child. Any child which exhibits difficulty in learning and subsequently requires adaptations in learning. Exceptionality may include physical (e.g., orthopedic), sensory (e.g., visual, hearing), or intellectual (e.g., mentally retarded, learning disabled) difficulties.

Instructional Programming. Based on behavioural model, this refers to the systematic application of selected techniques in teaching new and desirable behaviours (e.g., use of task analysis, shaping, and backward chaining).

Modelling. Demonstration of a desired behaviour or technique.

Programmed Instruction. A social learning modification of B. F. Skinner's (Hartley, 1974) approach to learning, programmed instruction includes the setting of objectives in teaching, the systematic analysis of steps towards this end, and evaluation and revision of the teaching presentation as needed.

RADEA Program. A set of task-analyzed instructional materials (Melton Peninsula, 1978) designed for use with developmentally delayed children and based on principles of instructional programming and Piaget's theory of child development. See Appendix B for a summary.

Role-playing. Rehearsing situations or techniques in a clinical or classroom setting.

Social Learning Theory. Based on the work of G. R. Patterson (1975), A. Bandura (1971), as expanded from earlier work by B. F. Skinner (1953), social learning states that (1) people teach each other, and (2) we are more likely to repeat behaviours that have pleasurable consequences and less likely to repeat behaviours that have unpleasurable consequences.

Task Analysis. Breaking a task down into steps and teaching the steps in order from the easiest to the most difficult.

APPENDIX E

ANALYSIS OF THE DATA: TABLES

Table 1

General Information

Parent	Sex of Parent	Age of Child	Sex of Child	Major Need of Child	Years of Education	No. of Sessions Attended
1	F	4-3	M	Behaviour	12	9
2-a	M	4-1	M	Behaviour	12	8
-b	F				9	9
3-a	M	6-2	M	Skill	10	9
-b	F			Acquisition	13	9
4-a	F	1-6	F	Skill	9	9
-b	M			Acquisition	12	8
5-a	M	3-8	F	Behaviour	18	8
-b	F				16	9
6-a	F	7-3	F	Skill	14	7
-b	M			Acquisition	??	6
7-a	F	6-11	F	Skill	11	9
-b	M			Acquisition	10	9
8	F	9-6	F	Behaviour	11	9
9	F	6-6	M	Behaviour	18	9
10-a	F	3-4	M	Skill	12	9
-b	M			Acquisition	10	9
11-a	M	2-6	M	Behaviour	16	9
-b	F				17	8
12-a	M	8-1	M	Behaviour	16	8
-b	F				16	9
Mean		5-1			13.1	8.52
Median		5-2			12	
Range		1-6 to 906			9 to 18	6 to 9

Table 2

RADEA Tasks Completed (Numbers are Cumulative)

Parents	Still Working on Task?			RADEA Tasks Completed			Steps Completed Within Tasks		
	End of Course	1-month	2-month	End of Course	1-month	2-month	End of Course	1-month	2-month
1	+	+	+	1	2	3	5	10	14
2	+	+	+	2	5	6	8	12	18
3	+	+	+	2	2	3	8	8	12
4	+	+	-	0	1	1	5	6	6
5	+	+	+	2	5	6	4	8	26
6	+	-	-	1	1	1	4	4	4
7	+	+	+	1	2	2	5	8	8
8	+	+	-	1	2	2	3	3	3
9	+	+		1	3		6	17	
10	+	+		0	1		12	16	
11	+	+		1	1	5	5	11	
12	-	+		0	0	0	0		
Total				12	25	24	65	103	91
Mean				1	2.27	3	5.42	9.3	11.4
Median				1	2	3	5	11	10.5
Range				0-2	1-5	1-6	0-12	4-11	3-26
%	91.66%	91.66%	62.5%						

Key: + = yes; - = no

Table 3a

Behaviour Change

Parents	Is Behaviour Chosen During Course Still a Problem?			Working on a Behaviour Program?		
	End of Course	1-month	2-month	End of Course	1-month	2-month
1	+	+	-	+	+	-
2	+	+	+	+	+	+
3	-	-	-	+	+	+
4	+	+	-	+	+	-
5	+	+	+	+	+	+
6	+	+	+	+	+	+
7	-	-	-	+	+	+
8	+	+	+	-	-	-
9	+	+		+	+	
10	+	+		+	+	
11	-	-		+	+	
12	+	+		+	+	
%	75%	75%	50%	92%	92%	62/5%

Key: + = yes; - = no

Table 3b

Behaviour Change

Parents	Direction of Behaviour Change									Generalization: Other Behaviours	Principles Used With Siblings		
	End of Course			1-month			2-month						
	Better	Same	Worse	Better	Same	Worse	Better	Same	Worse		Behaviours?	Skills?	N/A
1	+	-	-	+	-	-	N/A	-	-	+			+
2	+	-	-	-	+	-	-	+	-	+	+	-	-
3	+	-	-	N/A			N/A	-	-	+	-	-	
4	-	+	-	-	+	-	-	+	-	-	-	-	
5	+	-	-	-	+	-	-	+	-	+			+
6	+	-	-	-	+	-	+	-	-	+	-	-	
7	+	-	-	N/A			N/A	-	-	+			+
8	-	+	-	-	+	-	-	-	+	-	+	-	
9	+	-	-	+	+	0				+			+
10	-	+	-	+	-	-				+	-	+	
11	+	-	-	N/A						+			+
12	+	-	-	-	+	-				+	+	-	
%	75%	25%	0%	33.3%	66.6%	0%	20%	60%	20%	75%	42.9%	14.3%	41.6%

Key: + = yes; - = no; N/A = not applicable

Table 4

Overall Scores (in %)

Parent	Pre-Test	Post-Test	Change Score	Standardized Interview	Videotaped Performance
1	-	59%	-	82%	85%
2-a	37	73	+36		
-b	42	56	+14	75	100
3-a		40	-		
-b	33	54	+21	73	-
4-a	48	72	+24	11	100
-b	22	72	+50		
5-a	64	80	+16	73	48.6
-b	40	80	+40		
6-a	60	82	+22	55	-
-b	57	44	-13		
7-a	18	62	+44	90	-
-b	29	78	+49		
8	46	-	-	33	-
9	72	80	+9	78	92.9
10-a	53	88	+35	70	76.9
-b	39	60	+31		
11-a	60	86	+26	100	100
-b	59	92	+33		
12-a	54	68	+14		
-b	35	83	+58	67	-
Mean	45.7	70.5	+28.2	61	86.2
Median	46	72.5	+28.5	73.5	92
Range	18-72	40-92	-13 to +58	11-100	48.6-100

Table 5

Analysis of Questions on Test 2

	Total	Theory	Selecting a Behaviour	Teaching a Skill	Reinforcement	Negative Behaviour	Recording
Overall:							
Mean	70.45%	60.5	53.3	83.4	69.5	67.5	89.2
Median	72.5	60	66.6	87.5	83.3	75	100
Range	40-92	20-100	0-100	37.5-100	33.3-100	0-100	50-100
Group I:							
Mean	68.5	61.5	48.7	82.7	64.7	55.4	84.6
Median	72	60	66.6	87.5	75	50	83.3
Range	40-82	20-80	0-66.6	37.5-100	33.3-83.3	0-100	50-100
Group II:							
Mean	79.57	71.4	61.9	87.5	78.5	85.7	97.6
Median	83.3	60	66.6	87.5	83.3	75	100
Range	60-92	40-100	33.3-100	75-100	33.3-100	75-100	83-100

TABLE VI:

Name

OVERALL EVALUATION OF THE PROGRAM

1. Number of Sessions:

(a) Overall:

far too many	slightly too many	about right	slightly too few	far too few
	1	17		

(b) Instructional Programming:

far too many	slightly too many	about right	slightly too few	far too few
	2	18		

(c) Behaviour Management:

far too many	slightly too many	about right	slightly too few	far too few
		13	7	

2. Length of Sessions:

far too long	slightly too long	about right	slightly too short	far too short
	2	17		

3. Value of Questions on Answer Sheets:

very helpful	quite helpful	acceptable	of little use	of no use at all
8	7	5		

4. Value of Home Assignments:

very helpful	quite helpful	acceptable	of little use	of no use at all
9	6	5		

5. Amount of information covered:

far too much	slightly too much	about right	slightly too little	far too little
		18	1	

6. Amount of time between meetings:

far too much time	slightly too much time	about right	slightly too little time	far too little time
		19		

7. Number of Demonstrations:

far too many	slightly too many	about right	slightly too few	far too few
		17	2	

8. Appropriateness of the program for your child:

very appropriate	quite appropriate	acceptable	quite inappropriate	very inappropriate
11	2	1 6		

9. Time devoted to your family during sessions:

far too much	slightly too much	20 about right	slightly too little	far too little
☐	☐	☐	☐	☐

10. Time allowed for families to talk informally during meetings.

far too much	1 slightly too much	19 about right	slightly too little	far too little
☐	☐	☐	☐	☐

11. Instructors:

(a) Did they help to clarify the information?

18 very helpful	6 quite helpful	acceptable	of little use	of no use at all
☐	☐	☐	☐	☐

(b) Were they organized?

15 very organized	4 quite organized	1 acceptable	not very organized	not organized at all
☐	☐	☐	☐	☐

(c) Did they use clear examples?

15 very clear	4 quite clear	1 acceptable	not very clear	confusing
☐	☐	☐	☐	☐

12. Did the program satisfy your expectations?

9 very much	9 quite a bit	2 acceptable	only slightly	not at all
☐	☐	☐	☐	☐

13. Was the program helpful to you?

(a) Overall

10 very helpful	10 quite helpful	acceptable	of little use	of no use at all
☐	☐	☐	☐	☐

(b) Instructional Programming:

9 very helpful	9 quite helpful	2 acceptable	of little use	of no use at all
☐	☐	☐	☐	☐

(c) Behaviour Management

11 very helpful	8 quite helpful	1 acceptable	of little use	of no use at all
☐	☐	☐	☐	☐

14. Please indicate your preference of change for the method of material presentation.

	More	Same	Less
Lecture	3	14	
Questions on Answer Sheet	1	18	1
Demonstrations	8	12	
Discussions	5	14	1
Examples	5	15	
Role Playing	2	18	
Assignments	2	18	
Implementation	2	18	

15. Was there a point at which you noticed a change in your attitude toward the program? Yes 8 No 10 If yes, when did this attitude change? (i.e., 1st, 2nd session, etc) Why did your attitude change? What happened to change your attitude?

SESSION NUMBER:									
NO TIME SPECIFIED	1	2	3	4	5	6	7	8	9
2		3		1		1			

16. This is a pilot project. One of the purposes of this evaluation is to decide whether the psychology department should offer more of these educational programmes. Do you feel other parents could benefit from programmes like these?

Yes 20 No

17. What was most helpful about the sessions?

(a)	SKILLS: 5	DISCUSSION: 3		SUPPORT & IDEAS OF OTHER PARENTS: 5	
(b)	BEHAVIOUR MANAGEMENT: 10	HOME ASSIGN-MENTS: 4			
(c)	INSTRUCTORS: 1	EXAMPLES, VIDEOS: 4		AWARENESS OF PARENTS' OWN BEHAVIOUR: 7	

18. What changes would you suggest to make the sessions more useful?

INCLUDE WRITTEN MANUAL: 4		PROVIDE A LIST OF REFERENCES: 1	
MAKE THE SESSIONS SHORTER: 2		ELIMINATE "STOP TAPE": 1	
USE MORE EXAMPLES: 2			

19. Any additional comments?

THANK-YOU FOR YOUR HELP!

Table 7

Evaluations of Individual Sessions

	Session Number								
	1	2	3	4	5	6	7	8	9
1. Length of Session:									
far too long	0	0	0	0	0	0	0	1	0
slightly too long	5 (2)	0	0	0	6	0	1	2	3
about right	14 (3)	14	19	15	11	19	18	19	17
slightly too short	0	1	0	0	0	1	1	0	0
far too short	0	0	0	0	0	0	0	0	0
2. Clarity of Instruction:									
very clear	5 (1)	6	11	7	3	8	7	12	10
clear	12 (4)	9	8	2	9	11	9	9	10
acceptable	2	0	0	0	4	1	3	0	0
not very clear	0	0	0	0	0	0	0	0	0
confusing	0	0	0	0	1	0	0	0	1
3. Demonstrations:									
a. usefulness -									
very helpful	7 (1)	10	12	8	3	8	10	13	8
quite helpful	6 (3)	4	6	7	10	9	7	9	11
acceptable	5 (1)	1	1	1	4	3	2	0	2
of little use	1	0	0	0	0	0	0	0	0
of no use at all	0	0	0	0	0	0	0	0	0
b. clarity -									
very clear	4	8	12	8	2	8	6	13	5
clear	12 (4)	5	7	5	11	9	9	7	12
acceptable	2 (1)	2	0	2	2	3	3	1	2
not very clear	0	0	0	0	0	0	0	0	1
confusing	0	0	0	0	1	0	1	0	0

Table 7 continued:

	Session Number 1	2	3	4	5	6	7	8	9
4. Content:									
far too complicated	0	0	0	0	0	0	0	0	0
slightly too complicated	0 (1)	1	0	0	1	0	0	1	1
about right	19 (3)	13	19	11	16	20	19	20	20
slightly too simple	0	1	0	3	0	0	1	0	0
far too simple	0	0	0	0	0	0	0	0	0
5. Amount of Information Covered:									
far too much	0	0	0	0	0	0	0	0	0
slightly too much	0	0	0	0	0	0	0	1	1
about right	15 (4)	14	17	12	16	18	17	18	20
slightly too little	4 (1)	1	2	2	1	2	3	2	0
far too little	0	0	0	0	0	0	0	0	0
6. Level of Interest:									
very interesting	13 (3)	7	10	4	4	8	11	10	10
quite interesting	8 (2)	8	7	9	9	7	6	7	8
acceptable	3	0	2	3	4	5	3	5	4
quite boring	0	0	0	0	0	0	0	0	0
very boring	0	0	0	0	0	0	0	0	0
7. Questions on Answer Sheet:									
a. clarity -									
very clear	3 (1)	8	9	9	5	-	10	10	8
quite clear	11 (2)	4	7	4	6	-	6	9	8
acceptable	3	3	3	2	5	-	4	2	5
not very clear	1	0	0	0	0	-	0	0	0
confusing	1 (2)	0	0	0	1	-	0	0	0
b. amount -									
far too much	1	0	0	0	0	-	0	0	0
slightly too much	0	0	0	0	1	-	0	0	0
about right	13 (5)	4	18	11	12	-	19	20	21
slightly too little	0	1	1	2	3	-	1	1	0
far too little	0	0	0	1	0	-	0	0	0

Table 7 continued:

	Session Number								
	1	2	3	4	5	6	7	8	9
8. Home Assignment:									
a. clarity -									
very clear	6 (2)	6	10	6	6	10	9	9	-
quite clear	10 (1)	8	6	8	9	5	6	8	-
acceptable	3 (2)	0	2	1	1	4	5	4	-
not very clear	0	1	0	0	0	0	0	0	-
confusing	0	0	0	0	1	0	0	0	-
b. amount -									
far too much	0	0	0	0	0	0	0	0	-
slightly too much	0	0	0	0	0	0	0	0	-
about right	18 (5)	14	17	14	17	18	20	20	-
slightly too little	0	1	1	1	0	1	0	0	-
far too little	1	0	0	0	0	0	0	1	-
9. Appropriateness of this Material for your Child:									
very appropriate	6 (1)	5	7	5	4	7	11	11	10
quite appropriate	7 (1)	5	9	4	7	5	3	4	2
acceptable	5 (2)	4	2	6	6	6	6	5	8
quite inappropriate	1	1	0	0	0	0	0	1	1
very inappropriate	0	0	0	0	0	0	0	0	0

10. Suggestions for Improvement:	Session Number	Number Making Comment
a. Less philosophy, more practical knowledge	1	1
b. Want management skills primarily	1,4,6,7	5
c. Poor quality of videotape	1,3,4	3
d. Initial questionnaire was threatening	1	1
e. Make "STOP TAPE" segment shorter	1	1
f. A smaller group is preferred	2	1
g. More demonstrations	4	1
h. With the exception of the star-chart, last tape more for parents of older children	9	1

Table 8

Dropouts

Parent	Sex of Parent	Age of Child	Sex of Child	Major Need of Child	Years of Education	Number of Sessions Attended	Pre-test Score	Stated Reason for Dropout
13	M	5-9	F	Behaviour	15	1	14	Child no longer living with parents.
14-a -b	M F	7-0	M	Behaviour	6 7	2 2	19	Unknown.
15	F	8-5	F	Skill Acquisition	12	1	36	Unknown.
16	F	5-0	F	Behaviour	12	1	55	Unknown.
17	F	6-4	M	Behaviour	16	1	76	Child no longer living with Parent.
Mean		6-5			11.3	1.3	40	
Median		6-4			12		36	
Range		5-0 to 8-5			6-16		14-76	

APPENDIX F

SUGGESTIONS FOR IMPROVEMENTS ON INDIVIDUAL SESSIONS

SESSION I

a. Try to make the introductions as non-threatening as possible. A round-robin parlour game might break the ice.

b. When giving the pre-test, discuss how tests become associated with punishment and how social learning theory differs from the more traditional model of connoting that passing = good and failing = bad.

c. Try to find better clips of children for the introduction; find a dramatic example of improvement using task analysis and behaviour management.

d. Ask only Questions 1 and 2 during the session (and clarify the wording); give Question 3 as a home assignment.

e. Make a baseline videotape of the parent and child and/or make an initial home visit.

SESSION II

a. When giving the assignment for a task analysis, use a better example. Writing with a pencil is not as clear-cut as putting on a sock.

b. Give examples of task analysis and assessment with higher developmental levels as well, so that all parents can identify with the examples used.

SESSION III

a. When listing the six components of instructional programming, provide an outline for reference.

b. When asked to stop the tape and answer "where" and "when," clarify that this is on the home assignment sheet.

c. Instead of videotaping the RADEA cards (which were not readable), provide the examples in handouts.

d. Clarify the home assignment; tell parents to begin teaching the skill and to bring their problems to the next session.

e. Teach reinforcement sampling.

SESSION IV

a. Improve the examples of partial physical prompt.

b. Expand the session (possibly to two sessions) to deal with questions about refusal to participate, e.g.:

(1) What if the child refuses to come to the session?

(2) What if the child refuses to stay at the session or to cooperate in the task?

(3) What if the child has a temper tantrum?

and points such as:

(4) Grandma's rule.

(5) Role-playing of problems encountered?

c. Home assignment should be to continue teaching and bring in problems.

SESSION V

a. Role-play experiences of the week which concern the skill being taught.

b. Simplify the recording system.

c. Correct the example of recording of Grant on the Daily Progress Sheet. It should be: 5/6/10 NOT 5/5/10.

d. Reinforcement:

(1) Revise the checklist with better examples for children. The manual should give examples of reinforcers that have worked for other people.

(2) When filling out the list of possible reinforcers, clarify which reinforcers would be better as immediate reinforcers and which are better as delayed reinforcers.

3. Consider combining the section on reinforcement with the one on dealing with behaviour problems in an individual training session (mentioned in Session IV). These could combine to make an extra tape.

SESSION VI

a. Provide a time break between Sessions V and VI to allow for families to come in for a videotaped session.

b. Role play the teaching sessions and any problems encountered.

c. Evalute whether "Child Behaviour Equals You" is the best introductory tape. Investigate other possibilities.

d. Give a home assignment of finding a situation in the home for each of the following behaviour-consequence combinations:

B	C
+	+
+	–
+	0
–	+
–	–
–	0

SESSION VII

a. Select better examples of A-B-C and consider making your own vignettes, including some handicapped children.

b. Clarify the "Criticism Trap."

SESSION VIII.

a. Discuss removal of privilege rather than practice.

b. Clarify that it is best to use natural consequences when removing a privilege.

c. Use a better demonstration of restraint as well as other uses of it and alternative ways of restraining.

d. Give vignettes (or examples) and ask the parent how they would handle the situation, with a follow-up of an optimal way of handling the situation.

e. Clarify the definition of a punisher.

f. Role-play ignoring, time-out, and restraint.

g. Increase the time span between sessions to allow videotaping.

SESSION IX.

a. Look at possibly expanding Sessions VIII and IX into three tapes. An expansion might include:

(1) an explanation of how to use each contingency, including examples of actually explaining the system to the child and then carrying it out;

(2) a better explanation of how to combine positive and negative consequences into a system; how to set it up, monitor, and record simply;

(3) a discussion of restraints in the home, with vignettes of handling unanticipated situations. Questions for the parents regarding how they would handle a given situation in their own home.

b. A change in the answer sheet as there is insufficient time to write the answers unless the session is expanded to two.

c. Better examples of reinforcement systems for nonverbal children.

d. A clarification of ways of using stars, points, and contracting; how to choose; how to explain to the child; and how to make changes.

e. An arrangement for a final videotape session and/or home visit.

APPENDIX G

SAMPLE ANSWER SHEETS

SESSION I ANSWER SHEET

1. How is the exceptional child like all other children?

2. Name two ways in which your child may differ from the average child:

   A.

   B.

3(a) Describe at least one way in which your child needs special help in learning:

3(b) Describe one technique that you have used to help him/her to learn:

SESSION I: HOME ASSIGNMENT SHEET

1. Select a section of Radea on which you would like to work with your child:

_____ Visual Perception

_____ Auditory Perception

_____ Perceptual Motor

_____ Oral Language

_____ Functional Living

2. Observe your child and describe one skill he/she is learning now in the above area:

SESSION II: ANSWER SHEET

1. Briefly define Task Analysis:

2. The task analysis of picking up a pencil to write is:

3. What is the purpose of an assessment?

SESSION II: HOME ASSIGNMENT

Assess where your child should begin learning in an area you have selected from the Redea Program:

SESSION 111 ANSWER SHEET

1. What are the two things you should consider when setting up the environment?

   A.

   B.

2. Why is it important to get the child's attention.

3. What should precede an instruction?

4. All instructions should be _____ and _____.

5. How long do you wait before you decide to ignore or assist?

HOME ASSIGNMENT SHEET

1. Where in your home will you teach the skill?

   When?

   How often?

2. What materials will you use?

3. Gather materials listed in #2.

4. Practice doing two teaching cycles at home.

   Cycle I
   1) Get child's attention
   2) Give instruction
   3) Wait for a response
   4) Get a response and give reinforcement

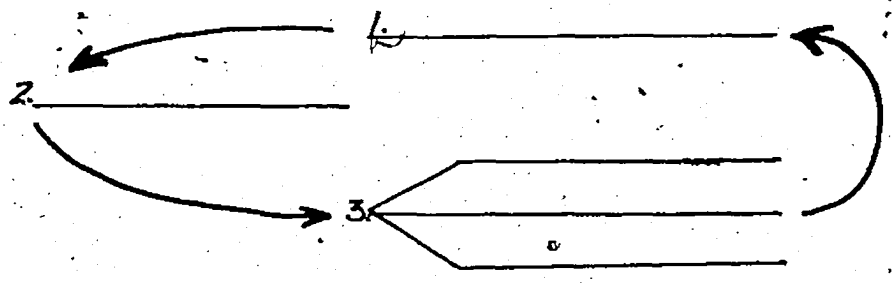
   Start at one again

   Cycle II
   1) Get child's attention
   2) Give instruction
   3) Wait for a response
   4) Ignore for a count of 10

   Start at one again

SESSION IV ANSWER SHEET

1. Briefly define the 3 stages of a trial.



2. List 5 ways of giving instruction or helping your child to give a response.

a) _____

_____

b) _____

_____

c) _____

_____

d) _____

_____

e) _____

_____

Session V Answer Sheet

1. List 2 rules about a reinforcer.

   a)

   b)

Home Assignment

Teach your child the skill you have chosen. Record your child's responses on both the Task Trial Sheet and the Daily Progress Sheet.

A questionnaire to identify reinforcers.

This questionnaire is designed to help you find some specific individuals, objects, events, or activities that can be used as reinforcers in an improvement program. Read each question carefully, and then fill in the appropriate blanks.

A. Consumable Reinforcers: What does this person like to eat or drink?

1. What things does this person like to eat most?
   a) regular meal-type foods_____
   b) health foods-(dried fruits, nuts, cereals, etc.)_____
   c) junk foods-popcorn, potato chips, etc._____
   d) sweets-candies, ice cream, cookies, etc._____

2. What things does this person like to drink most?
   a) milk_____ c) juices_____
   b) soft drinks_____ d) other_____

B. Activity Reinforcers: What things does this person like to do?

1. Activities in the home or residence
   a) hobbies_____
   b) crafts_____
   c) redecorating_____
   d) preparing food or dishes_____
   e) housework_____
   f) odd jobs_____
   g) other_____

2. Activities in the yard or courtyard
   a) sports_____
   b) gardening activities_____
   c) barbecue_____

d) yard work_____

e) other_____

3. Free activities in the neighborhood (window shopping, walking, jogging, cycling, driving, swinging, teeter-tottering, etc.)

4. Free activities further away from home (hiking, snow shoeing, swimming, camping, going to the beach, etc.)_____

5. Activities you pay to do (films, plays, sport events, night clubs, pubs, etc.)_____

6. Passive activities (watching TV, listening to the radio, records, or tapes, sitting, talking, bathing, etc.)_____

C. Manipulative Reinforcers: What kinds of games or toys does this person like to play with?

1. Toy cars and trucks_____

2. Dolls_____

3. Wind-up toys_____

4. Ballons_____

5. Whistle_____

6. Jump rope_____

7. Coloring books and crayons_____

8. Painting kit_____

9. Puzzles_____

10. Other_____

Page 3-A questionnaire to identify reinforcers

D. Possessional Reinforcers: What kinds of things does this person like to possess?

1. Brush
2. Nail Clippers
3. Hair clips
4. Comb
5. Perfume
6. Belt
7. Gloves
8. Shoelaces
9. Other

E. Social Reinforcers: What kinds of verbal or physical stimulation does this person like to receive from others (specify why)?

a) "Good girl (boy)"
b) "Good work"
c) "Good job"
d) "That's fine"
e) "Keep up the good work"
f) Other

2. Physical contact

a) hugging
b) kissing
c) tickling
d) patty-cake
e) wrestling
f) bouncing on knee
g) other

SESSION V1 HOME ASSIGNMENT

1. Continue to teach your child a skill.

2. Watch your child to see when and where undesired behaviours occur and what happens after the behaviour.

SESSION V11 : ANSWER SHEET

1. Do a precise description of your own child's behaviour (using the A-B-C form).

2. What are 3 things you should consider when selecting a behaviour to change:

   a)

   b)

   c)

3. List 2 ways of recording behaviours.

   a)

   b)

4. Select the method of recording which is most appropriate for the behaviour you precisely described previously.

Antecedents	Behaviour	Consequences

HOME ASSIGNMENT

1. Continue teaching the skill you have selected.

2. Observe, and do a precise description (using the A-B-C) of a behaviour to change.

3. Record either how long or how many times the behaviour occurs.

4. Bring in your A-B-C and recording sheet next time.

SESSION VIII MANAGING BEHAVIOUR PART C

1. Ignoring:
   Which scene is the correct one and why?

2. Putting a child on a chair:
   Which scene is the correct one and why?

3. Time out:
   Which scene is the correct one and why?

4. Physical Restraint:
   Which scene is the correct one and why?

5. Practice Removal of Privileges in the following four situations:
   a) tearing up a toy
   b) playing around with the T.V.
   c) not making the bed in morning
   d) taking a long time to get down for breakfast.

SESSION V111: MANAGING BEHAVIOUR PART C-PAGE TWO

Home Assignment

For 2-3 days count the number of praises and criticisms you give to your child.

SESSION 1X: MANAGING BEHAVIOUR, PART D

1. List 5 Common Errors in making a change:

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

2. STAR CHART:

   Work out a star chart program for a child who is a bedwetter.

3. TOKENS/POINTS:

   a. Select one desirable behaviour and its payoff

   b. Select one undesirable behaviour and its fine.

   c. List 4 possible reinforcers and their prices.

   Reinforcers Price

   1. _____

   2. _____

   3. _____

   4. _____

3. continued

d. Briefly explain how the token economy would work.

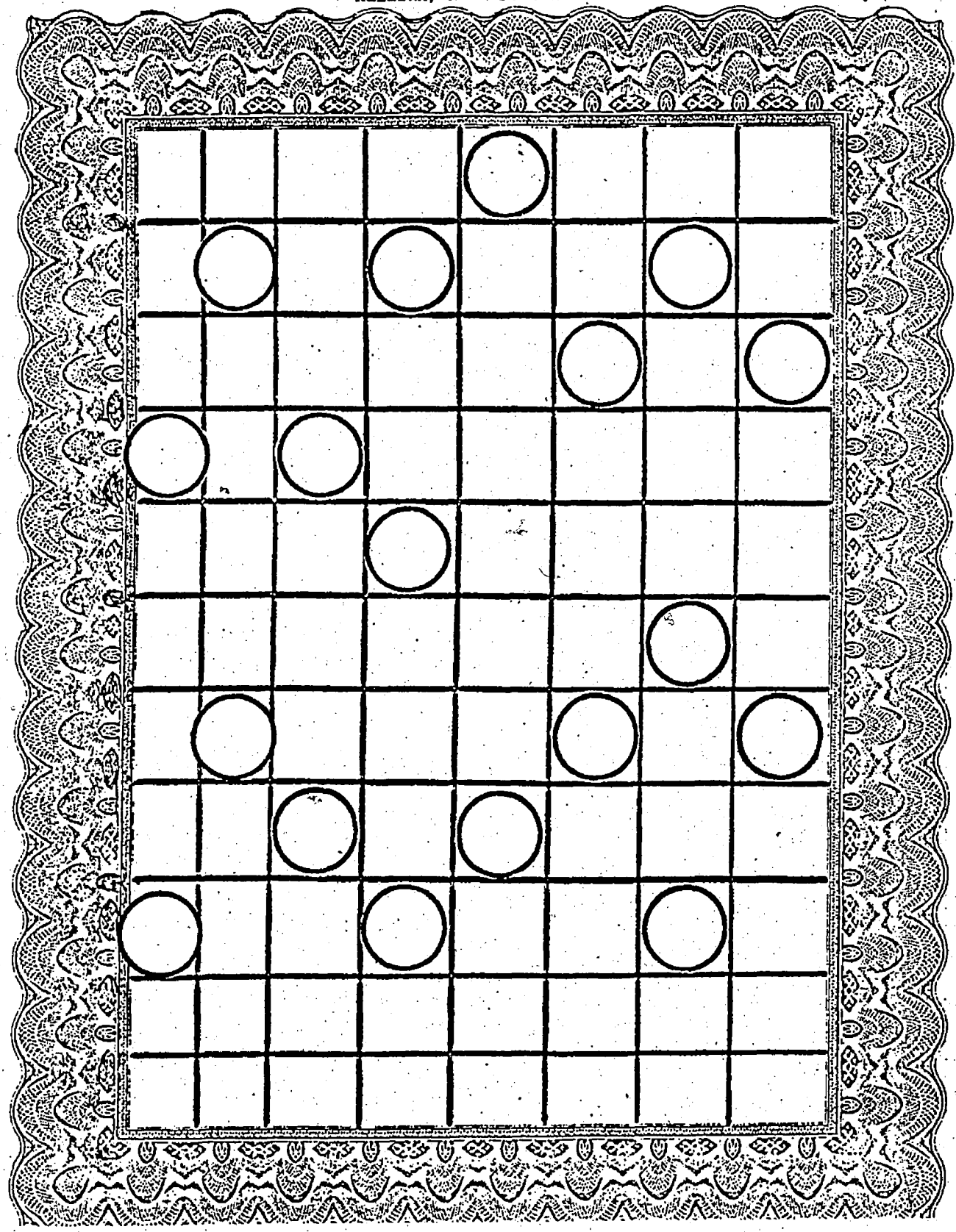
4. CONTRACTING

Make up a contract to change a behaviour you have selected.

REMEMBER

1. SELECT A BEHAVIOUR TO CHANGE
2. DO AN A-B-C.
3. SELECT A RECORDING METHOD
4. SELECT THE CONSEQUENCES
5. MAKE A CHANGE
6. EVALUATE
7. TRY, TRY AGAIN!

THE IZAAK WALTON KILLAM HOSPITAL FOR CHILDREN
Halifax, Nova Scotia



Desirable Behaviours

	Pay off	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S
1.															
2.															
3.															
4.															
5.															

Undesirable Behaviours

	Fine	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S
1.															
2.															

Possible Reinforcers

	Price	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															

NO BANKRUPTCY-NO ADVANCES-NO CREDIT-NO MILLIONAIRES

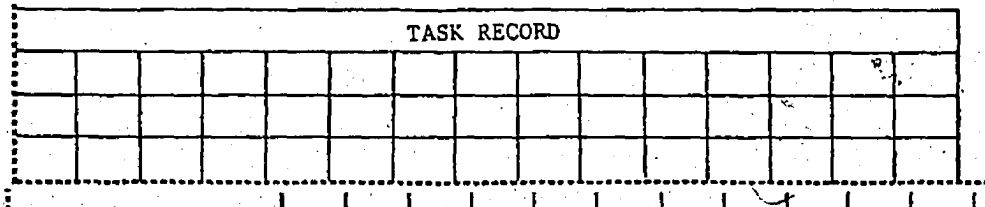
CONTRACT

TASK	REWARD
Who:	Who:
What:	What:
When:	When:
How Well:	How Much:

Sign Here: _____ Date: _____

Sign Here: _____ Date: _____

TASK RECORD



TASK RECORD

Sign Here: _____ Date: _____

Sign Here: _____ Date: _____

REWARD	TASK
Who:	Who:
What:	What:
When:	When:
How Much:	How Well:

APPENDIX H

EVALUATION FORMS

GENERAL INFORMATION

Child's Name:_____

Date of Birth: _____

School Attended:_____

Mother's Name:_____

Occupation_____
Last year of education completed_____

Father's Name:_____

Occupation_____
Last year of education completed_____

Address:_____

Phone Number:_____

YOUR CHILD'S PROBLEMS:

1. Physical:

   a) Can your child walk?_____
   b) Does your child have difficulty with large motor movements?_____
      (i.e., balance, smoothness of movement).
   c) Does your child have difficulty with fine motor movements?_____
      (i.e., grabbing an object using both hands together, hand steadiness).
   d) Does your child use any orthopedic aids?_____
      If so, what?_____

2. Visual:

   a) Does your child have a visual loss?_____
   b) If so, how much vision does s(he) have?_____
   c) Does your child use any visual aids?_____

3. Hearing:

   a) Does your child have a hearing loss?_____
   b) If so, how much hearing does s(he) have?_____
   c) Does your child use a hearing aid?_____

4. Speech:-How does your child communicate?

   a) By crying and laughing?_____
   b) By pushing or pulling you?_____
   c) By taking you to an object?_____
   d) By pointing?_____

Speech, Continued

e) By gesturing?_____
f) By using single words?_____
g) By speaking in phrases/sentences?_____
h) Other?_____

5. Milestones: At what age did your child--

a) Sit up alone?_____
b) Crawl?_____
c) Walk?_____
d) Feed self with a spoon?_____
e) Speak single words?_____
f) Speak sentences?_____
g) become toilet-trained?_____

6. Behaviour:

Below is a list of behaviour problems often reported by parents of children who have various learning problems. For each, please check how often this occurs at home and if it is a problem to you.

BEHAVIOUR PROBLEMS

ACTING OUT PROBLEMS	Never	1-3/mo	1-3/wk	4-6/wk	1-2day	3-4/day	5-10/day	more 10/day	Is this a problem for you? Yes	No
1. Temper Tantrums										
2. Hitting other children										
3. Hitting adults										
4. Spitting										
5. Throwing things										
6. Destroying(pulling down; tearing things)										
7. Biting or pinching people										
8. Vomiting										
9. Smearing bowel movements										
10. Undressing at inappropriate times										
11. Running Away										
12. Fire setting/playing with matches										
13. Other										

MEALTIME PROBLEMS

	Never	1-3 mo.	1-3 wk.	4-6 wk.	1-2 day	1-2 meal	3-4 meal	5 or more meal	Is this a problem for you? Yes	No
1. Throwing food										
2. Stealing food										
3. Putting hands in food										
4. Refusing food										
5. Spilling (intentionally) food										
6. Overeating										

SLEEPING PROBLEMS

	Never	Less than 1/mo	2-3 mo.	1/wk	2-3 wk.	1/night	More than 1/night	Is this a problem for you? Yes	No
1. Out of bed-wandering during night.									
2. Scream/cry during night or when put to bed.									
3. Nightmares									
4. Other:_____									

REPETITIVE BEHAVIOURS

Here estimate how much time he spends on each of these behaviours.

	Never	Less than 5 min/wk	2-5 min/ day	10 min/ day	30min/ day	1 hr/ day	2-4 hrs/ day	More than 4 hrs/day	Is this a problem for you? Yes No
1. Headbanging									
2. Rocking									
3. Bizarre gesturing or twirling objects									
4. Holding hands in strange positions									
5. Running-wandering aimlessly									
6. Nailbiting									
7. Thumbsucking									
8. Picking at or hitting self									
9. Whining or crying									
10. Falling all over people-clinging									
11. Other									

YOUR EXPECTATIONS OF THE COURSE

1. Please list 3 skills which you feel are most important for your child to learn right now. List them in order of priority from most to least important.

   a) _____

   b) _____

   c) _____

2. What do you hope to achieve from this program?

   a) for your child _____

   _____

   _____

   _____

   b) for yourself _____

   _____

   _____

   _____

   _____

   _____

PREVIOUS INSTRUCTION

1. Have you participated in a parent group before?_____

   If so:

   a) When?_____

   b) For how long?_____

   c) Who organized the group?_____

   d) What was the emphasis?_____

   _____ 1. Teaching skills to your child.

   _____ 2. Behaviour Management.

   _____ 3. Other

2. Have you individually received instruction or advice on working with your child re:

   a) Teaching skills to your child?_____

   From whom?_____

   b) behaviour management?_____

   From whom?_____

3. Are you familiar with the Radea Program?_____

4. Have you used task analyzed materials before?_____

   a) Radea?_____

   b) Other?_____

5. Have you read any books on this topic?_____

   If so, please list them:

   a) Teaching new skills:_____

   _____

   b) Behaviour management:_____

   _____

Name _____ Date _____

QUESTIONNAIRE

A. Please select the most appropriate answer from the list below;

Task Analysis	Reinforcement
Time Out	Social Learning Theory
Assessment	Fading
Piaget's Theory	

1. Turning one's head and avoiding eye contact for a count of 10 is an example of _____.
2. The idea that all children can learn is based on _____.
3. Gradually removing physical assistance is an example of _____.
4. Breaking a skill down into steps and then teaching one step at a time is an example of _____.
5. The idea that children learn in a certain sequence of stages of development and that early behaviours are stepping stones for later behaviours is based on _____.
6. Giving a child a quarter as soon as he/she finishes mowing the lawn would be an example of _____.
7. The idea that we are more likely to repeat a behaviour which has a pleasurable result and less likely to repeat a behaviour which has an unpleasurable result is based on _____.
8. Sarah is learning her colours; popcorn is used as a reward after every correct answer. When her father later begins to give popcorn for every few correct answers, while still praising every correct answer, this is an example of _____.
9. After Susan has kicked another child, sitting her in a chair by herself for 2 minutes is an example of _____.

B. Circle the best answer:

1. If a child is not performing well on some task, which of the following would be likely?

   (a) The reward is available elsewhere.

   (b) The directions are unclear.

   (c) The reward is contingent upon the task.

   (d) (a) and (c)

   (e) (a) and (b)

2. Sam's parents are teaching him to button his coat. A good method for teaching him would include:

   (a) Start by placing HIS hands on YOURS while you button his coat.

   (b) Use small buttons to fit his small hands.

   (c) Start by teaching him the last step involved in buttoning.

   (d) Two of the above.

   (e) None of the above.

3. The exceptional child is like the average child in that:

   (a) We assume that he/she follows a similar sequence of development.

   (b) He/she can learn

   (c) There are no similarities.

   (e) None of the above.

4. How long should you wait after giving an instruction before deciding to either ignore or give assistance?

   (a) As little time as possible.

   (b) Usually to a count of 30.

   (c) As long as it takes for a child to do it independently.

   (d) Usually for around 5 seconds.

   (e) None of the above.

5. You are going to teach Barb to tie her shoes. Which of the following would be the most effective reward to use?

   (a) Food, such as popcorn or M & M's.

   (b) Tokens, which can be traded in for something else.

   (c) Affection, as a hug or praise.

   (d) Watching TV.

   (e) Cannot say.

6. Which of the following behaviours are clearly defined:

   (a) Being lazy.

   (b) Hitting one's head.

   (c) Acting stubborn.

   (d) (a) and (b).

   (e) (b) and (c).

7. Most forms of punishment, such as hitting, screaming and spanking should be used sparingly because:

   (a) If the mother yells and screams at the children, then they will find ways of punishing her in return.

   (b) Mothers who yell and scold a lot have children who do the same.

   (c) Both of the above.

   (d) Neither of the above.

   (e) Cannot say.

8. Billy is constantly out of his seat in class. A new program is introduced which gives Billy a token every time he stays in his seat for 5 minutes. Which of the following would best suggest that a token works as a reward for Billy?

   (a) Billy is allowed to exchange his tokens for a variety of things which he enjoys.

   (b) Billy stays in his seat longer on each of the next three days.

(c) Billy proudly shows his token to teachers and visitors.

(e) Billy becomes very upset when another child steals his tokens.

9. When teaching a child at home, it is best to:

(a) Choose a place free from distractions.

(b) Teach him/her in a place with a variety of visual and auditory stimulations around him/her.

(c) Teach him/her at a time when he/she would normally perform the task.

(d) (a) and (c).

(e) (b) and (c).

10. The exceptional child is different from the average child in that:

(a) We always know by her/his diagnosis how far he/she will progress in the future.

(b) He/she may learn at a different rate.

(c) He/she may require more assistance in learning.

(d) She/he cannot learn.

(e) (b) and (c) above.

11. You are using food rewards (raisins), in teaching a child simple counting of a few objects at a time. He has just correctly counted a pile of blocks. In rewarding this correct response, you should:

(a) Immediately have him count another small pile and this provide him with two quick successes in a row.

(b) Wait a moment before giving him the raisin, to allow him to enjoy his success.

(c) Offer him several raisins if he can count a slightly larger pile.

(d) Praise him immediately and then give him a raisin right afterwards.

(e) Give him the raisin immediately, and then praise him right afterwards.

12. Which of the following would be considered a form of assistance in helping the child to respond:

(a) Gesturing.

(b) Verbal Prompt.

(c) Modelling.

(d) All of the above.

(e) None of the above.

13. Which of these would always be a punishment for any child?

(a) Placing him in a room alone.

(b) Telling him what a bad boy (or girl) he is.

(c) Scolding him angrily for his behaviour.

(d) Two of the above.

(e) None of the above.

14. Use of an "activity reward" involves two behaviours: A behaviour which the child enjoys doing; a different behaviour which you would like the child to perform.

When such a reward is used properly:

(a) The child can do the behaviour he likes after he performs the behaviour which you want.

(b) You permit the child to do the behaviour he wants, but only after he promises to do the behaviour which you want.

(c) You permit the child to do the behaviour he prefers, and when he tires of it, you encourage him to perform the behaviour you want.

(d) The child may do the behaviour which you want, before he can do any more of his preferred behaviour.

(e) The behaviour you want and the behaviour he likes are one and the same.

Name

EVALUATION OF SESSION #

1. Length of Session:

☐ far too long ☐ slightly too long ☐ about right ☐ slightly too short ☐ far too short

2. Clarity of Instruction:

☐ very clear ☐ clear ☐ acceptable ☐ not very clear ☐ confusing

3. Demonstrations:

(a) Usefulness -

☐ very helpful ☐ quite helpful ☐ acceptable ☐ of little use ☐ of no use at all

(b) Clarity -

☐ very clear ☐ clear ☐ acceptable ☐ not very clear ☐ confusing

4. Content:

☐ far too complicated ☐ slightly too complicated ☐ about right ☐ slightly too simple ☐ far too simple

5. Amount of Information Covered:

☐ far too much ☐ slightly too much ☐ about right ☐ slightly too little ☐ far too little

6. Level of Interest:

☐ very interesting ☐ quite interesting ☐ acceptable ☐ quite boring ☐ very boring

7. Questions on Answer Sheet:

(a) Clarity -

☐ very clear ☐ quite clear ☐ acceptable ☐ not very clear ☐ confusing

(b) Amount -

☐ far too much ☐ slightly too much ☐ about right ☐ slightly too little ☐ far too little

EVALUATION OF SESSION # _____ P. 2

8. Home Assignment:

(a) Clarity -

☐ very clear ☐ quite clear ☐ acceptable ☐ not very clear ☐ confusing

(b) Amount -

☐ far too much ☐ slightly too much ☐ about right ☐ slightly too little ☐ far too little

9. Appropriateness of This Material for Your Child:

☐ very appropriate ☐ quite appropriate ☐ acceptable ☐ quite inappropriate ☐ very inappropriate

10. Suggestions for Improvement:

VIDEOTAPES

NAME: _____

	# CORRECT	# INCORRECT	%
1. SET UP THE ENVIRONMENT:			
a. Gathers materials before starting			
2. GIVING INSTRUCTION			
a. Child's name spoken first			
b. Waits for attention before giving instruction (eye contact)			
c. Instruction is short & concise.....			
3. WAITING FOR A RESPONSE			
a. Waits at least 5 seconds..... (unles child responds sooner)			
4. IF NO RESPONSE:			
a. IGNORES:			
1) at least 5 seconds.....			
2) no eye contact.....			
3) no verbal contact			
b. GIVES ASSISTANCE:			
1) tries least amount first ..... (verbal/gesture--modeling--physical)			
2) uses form of assistance properly			
a) gives verbal/gestural/model; then waits ("You do it").....			
b) hands on; then waits for movement.			
5. REINFORCEMENT:			
a. Uses reinforcement sampling.....			
b. Reinforces immediately (within 5 seconds).			
6. ENDING SESSION:			
a. Ends on a success.....			
TOTAL SCORE: _____ %			

NAME: _____ DATE: _____

STANDARDIZED INTERVIEW

Introduction: "I'm calling as a follow-up to our parent group. I'd like to ask you some questions which are the same questions I'm asking to each family. I'd really appreciate your help in answering them.

A. TEACHING A SKILL

1. Are you still teaching the task you began teaching in the group?
yes____ no____

If yes:

a) What task are you working on:

Area_____ Task#_____ Step #_____

b. How many steps have you completed? _____

c. How are you teaching the task?

1) Where: _____

When: _____

2) How are you giving assistance:

Physical assistance_____

Physical prompt_____

Gesture_____

Verbal prompt_____

Modeling_____

3) Reinforcers used:

_____

_____

_____

4) Method of recording: Are you recording?

_____

5) How do you deal with negative behaviour:

Behaviour: _____

Method used: _____

_____

1. Are you teaching any new tasks?

yes_____ no_____

If yes:

a. What tasks:_____

b. What tasks have you completed_____

c. How did you select:

1) the task to teach:_____

2) the step to work on:_____

3) criteria for moving on to the next step/task:

_____

only if → d. How are you teaching the task(s)?
) is not answered

1) Where:_____

When:_____

2) How are you giving assistance:

- Physical assistance_____

Physical prompt_____

Gesture_____

Verbal prompt_____

Modeling_____

3) Reinforcers used@

_____

_____

_____

4) Method of recording:

_____

5) How do you deal with negative behaviour:

Behaviour:_____

Method used:_____

_____

_____

3. Are you teaching any skills to any siblings?

yes_____ no_____

If yes:

a. What task are you working on:_____

b. What tasks have you completed_____

c. How did you select:

1) the task to teach:_____

2) the step to work on:_____

3) criteria for moving on to the next step/task:

_____

d. How are you teaching the task(s)?

1) Where:_____

When:_____

2) How are you giving assistance:

Physical assistance_____

Physical prompt_____

Gesture_____

Verbal prompt_____

Modeling_____

3) Reinforcers used:

_____

_____

_____

a. What was the frequency when you began:

_____

What is the frequency now:

_____

What was the duration when you began:

_____

What is the duration now:

_____

c. What are you using as a reinforcer:_____

_____

_____

d. How are you dealing with the negative behaviour:

_____

_____

3. Have you used the principles on any other Siblings?

yes_____ no_____

If yes:

a. What behaviours: _____

_____

b. What was the frequency when you began:

_____

What is the frequency now:

_____

What was the duration when you began:

_____

C. What are you using as a reinforcer:_____

_____

_____

d. How are you dealing with the negative behaviour:

_____

_____

APPENDIX I

DROPOUT QUESTIONNAIRE

The IZAAK WALTON KILLAM
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I/We did not continue to attend the groups because: _____

_____

_____

_____

THE GROUPS WOULD HAVE BEEN BETTER FOR ME/US BY:

☐ 1. Making the material more appropriate for my child. How? _____

_____

_____

_____

☐ 2. Changing the size of the group. (_____Larger?_____smaller?)

☐ 3. Changing the length of the session.(_____longer?_____shorter?)

☐ 4. Changing the day of the week.

☐ 5. Changing the time of the day. (What time would be better? _____)

☐ 6. Making the information clearer?

☐ 7. Making the information more interesting.

☐ 8. Changing the method of presenting the information:

	More	Less
videotaped instruction		
videotaped demonstrations		
questions on answer sheet		
role playing		
discussions		
home assignments		

9. Would you be interested in attending a group in the future? yes ____ no _____

10. Other suggestions for improvment: _____

_____

_____

_____