TRAINING FAMILY THERAPISTS: AN EXPERIMENTAL ANALYSIS

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This study implemented and evaluated a training program (a written manual, videotaped models, rehearsal, role plays, and performance feedback) designed to teach five subjects the skills to become effective family therapists. The study examined the therapists' use of three target behaviors: instructing, informing, and praising. The therapists, each paired with a parent and a preschool-aged child (2½-4½ yr old), were trained in the clinic to use, and to teach to the parents, several behavioral skills (e.g., praising, planned ignoring, and time-out) relevant to teaching children compliance to parental instructions. A multiple-baseline design across triads (therapist/parent/child) demonstrated that after the training program was instituted, the therapists increased their rates of instructing, praising, and informing the parents; all parents increased attention to compliance, decreased attention to noncompliance, and increased rates of praise to their children; and all children increased their compliance and decreased their noncompliance.

DESCRIPTORS: training therapists, parent-child interaction, parent training

Administrators and researchers in educational, social service, and mental health facilities are becoming increasingly aware of the need for training programs that both improve the professional skills of their personnel (Quilitch, Miller, McConnell, & Bryant, 1975) and assess the therapeutic gains of their clients (Bouchard, Wright, Mathieu, Lalonde, Bergeron, & Toupin, 1980). These professionals are discovering that many training programs often do not adequately prepare their personnel (or students) to remediate client problems effectively. Garfield and Kurtz (1976), reporting the results of a survey of clinical psychologists, found that one in every four respondents was dissatisfied with their training and felt insufficiently prepared for the profession. Academicians, professionals, and re-

spondents to surveys have noted, in particular, the need for more supervised clinical experience in which the trainee has first-hand contact with clients and is actively engaged in the therapeutic process (e.g., Dancer, Braukmann, Schumaker, Kirigin, Willner, & Wolf, 1978; L'Abate, Berger, Wright, & O'Shea, 1979; Marholin, Taylor, & Warren, 1978; Wisocki & Sedney, 1978). In addition, clinical practitioners have recommended a greater emphasis on clinical techniques and a better balance between theory and practice (Ford, 1979).

Studies should carefully consider three basic issues in validating any training program (Garfield, 1977; Matarazzo, 1971): (a) the selection, definition, and measurement of the specific behaviors that constitute the therapeutic skills to be taught, (b) procedural descriptions of the teaching methods that facilitate therapist acquisition and maintenance of these skills, and (c) evaluation of the program's effectiveness in terms of positive changes in clients (Bouchard et al., 1980).

The behaviors that have been observed in, or taught to, therapists include: problem specification, rationale giving, self-monitoring, role play-

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ing, giving feedback, modeling (Wright, Horlich, Bouchard, Mathieu, & Zeichner, 1977); praise statements, smiles (Maloney, Phillips, Fixsen, & Wolf, 1975); minimal encouragement to talk, closed questions, open questions, reflection of content, reflection of feeling (Fyffe & Oei, 1979); approval, disapproval, neutral statements (Fabry & Reid, 1978); verbal instructions, reinforcement, physical prompts, and ignoring (Gladstone & Sherman, 1975).

Training methods have included: feedback about the trainee's performance (e.g., Bouchard *et al.*, 1980; Carlson, 1974; Fyffe & Oei, 1979; Payne, Winter, & Ball, 1972; Rickert & Turner, 1978); videotapes (e.g., Eisenberg & Delaney, 1970; Powell, 1975; Taber, 1976); instructions (e.g., Eskedal, 1975; Perry, 1975); behavior rehearsal (e.g., Bailey, Dearthoff, & Nay, 1977; Gladstone & Sherman, 1975; Levine & Tilker, 1974); modeling (e.g., Eskedal, 1975; Frankel, 1971; Goldberg, 1971; Hart, 1973; Saltmarsh, 1973); and audiotapes (e.g., Danish & Hauer, 1973; Sigal & Levin, 1976; Silverman & Quinn, 1974). A number of other studies has shown the superiority of multicomponent training packages which have combined several training methods such as modeling, instructions, rehearsal, videotapes, and feedback in producing reliable improvements in trainee skills (Bailey *et al.*, 1977; Bouchard *et al.*, 1980; Dancer *et al.*, 1978; Eisenberg & Delaney, 1970; Fabry & Reid, 1978). Because no specific technique has been found to be the most, or only, effective technique, the use of multiple-training techniques would appear to ensure maximally effective training.

Integral to the success of any training program for professionals is positive change in their clients. In a review of training programs for counselors and clinicians, Ford (1979) states, "Ultimately, it will be essential to demonstrate that changes in trainees' functioning that are generated by training interventions do, in fact, produce therapists who consistently provide effective therapy." (p. 91). Surprisingly, there are few training studies that document significant

positive changes in their target populations as a result of their training program while providing a precise description of the training procedures that were used and the trainee skills that were trained.

The experimental literature contains few examples of training family therapists. In studying training methods and reviewing the training literature, the authors found that three behaviors (instructing, informing, and praising) consistently appeared as dependent measures in training programs for diverse populations: for example, teachers (Rushall & MacEachern, 1977), teaching parents (Achievement Place Model, Maloney *et al.*, 1975), college students working as counselors (Powell, 1975; Talbert, Wildeman, & Erickson, 1975), family counselors (Mead & Crane, 1978), high school students working with handicapped children (Gladstone & Sherman, 1975), and foster grandparents working with institutionalized children (Fabry & Reid, 1978). To assess how these three therapist behaviors corresponded to positive outcomes in family functioning, this study defined therapist dependent variables as: (a) instructions to parents, (b) information about child development, child-rearing practices, and parent-child relationships, and (c) praise of parent performance.

The purposes of the following study were to test the effectiveness of a multicomponent training program to train family therapists and to evaluate resultant improvements in both parent and child behaviors.

METHOD

Participants

The fifteen participants in this study included five graduate students, hereafter referred to as trainees who served as therapists and were paired with five parents, each of whom had a preschool child.

Trainees. Four of the trainees were graduate students in various social sciences. Three trainees were recruited through the experimenter's con-

tacts with university personnel who supervised graduate students. After the nature of the training became more well known, two more students volunteered to be trainees. All the trainees expressed a strong interest in learning better ways to work with children and their parents. Trainee 1 had worked 8 yr as a social caseworker with abusive/neglectful families and was a first-year student in a Master of Social Work program. Trainee 2 had completed an M.S.W. degree and was working as a social caseworker in an institution for the mentally retarded. Trainee 3, the only male trainee, had completed an M.A. in Developmental and Child Psychology and was working as a preschool teacher. Trainee 4 was a second-year student in a clinical psychology program and had worked 1½ yr as a therapist as part of her clinical training program. Trainee 5 had worked 4 yr as a counselor in a residential medical facility for youths 8-16 yr of age and was a first-year graduate student in Developmental and Child Psychology.

Families. Each of the families included a parent and one of their preschool-aged children. The family, parent, and child characteristics are summarized in Table 1.

Procedures

This study was conducted in two parts: Trainees 1 and 5 participated with Families A and E in the fall of 1980, and Trainees 2, 3, and 4 participated with Families B, C, and D in the spring of 1981. Each trainee-family pair was involved in the study approximately 2½-3 mo.

Prior to their first session, each parent and trainee was interviewed to explain the purpose of the study, fill out consent forms, fill out a child history form and one other child assessment form (by the parents), answer questions, and schedules times for the future biweekly sessions. These interviews took place in the experimenter's office; subsequent sessions took place in a clinic room equipped with a one-way mirror and a sound system.

The trainees and families were paired (a) by finding time periods to conduct the sessions that were convenient for both the parents and the trainees, and (b) according to the severity of the families' needs and the experience of the trainees. Trainee 1 (T1), who had extensive experience working with abusive/neglectful parents, was paired with Family A (FA) because this parent frequently used excessive physical punishment to discipline her children and worried that she might hurt one of them. Trainee 2 (T2), who worked as a social caseworker with handicapped children, was paired with Family B (FB) because of their child's multiply handicapping conditions. The other three trainees and families were paired according to their mutual schedules: T3 with FC, T4 with FD, and T5 with FE.

Prior to the first session, the experimenter met with each trainee for approximately 30 min and explained what the trainee should do and say to the parent during the first and later baseline sessions. The experimenter told the trainee to explain the task and the rationale for base-

Table 1
Family, Parent, and Child Characteristics

Family	Number of Parents	Parent			Child		
		Income	Sex	Education	Sex	Age	Developmental Problems
A	1	Low	F	High School	M	2½	Speech, Language, Hearing, Behavior
B	2	Medium	F	High School	M	4½	Speech, Language, Learning Disabled, Behavior
C	1	Low	F	Some College	M	2½	Speech, Language, Behavior
D	2	Medium	M	Ph.D.	F	3	Behavior
E	2	Medium	F	Some College	M	2½	Behavior

line observations to the parent during the first session, but to avoid helping the parent and child in any way with the task.

After the initial meeting with the trainee, the experimenter met jointly with the parent and trainee for approximately 30 min to explain once again the purpose of the study and what they should expect during each phase of the study; and to allow the parent and trainee to meet each other and find out a little about each other's background, interests, and reasons for participating in the study. The experimenter then told the trainee to take the parent and child to the clinic room, and the experimenter and the observers took their places in the adjoining room.

The task, which was used throughout all experimental conditions (Instructional Training, Embry, 1980), assessed the parent's instructional control of the child's compliance. Twenty common toys were placed on the couch near the parent, and two or four containers (a paper bag, a cardboard box, a yellow bucket, and a red pan) were placed a few feet from the couch. Two containers were used with the language-delayed or handicapped children in Families A, B, and C, and four containers were used with the children in Families D and E. The parent, guided by a prepared list, instructed the child where to place each toy. Four different lists, identifying different placement of the toys, were used at random to prevent the children from memorizing where the toys were to be placed. The parent was to instruct the child to take one toy at a time and place it in the designated container. The task, which generally took 5-30 min, was completed when all the toys were placed in a container (correctly or incorrectly), or when the child had engaged in tantrums or other aversive behavior continuously for 10 min or (only during the intervention periods) when the trainee terminated the task.

Data Collection

The trainee behaviors that were recorded included instructions to carry out procedures im-

mediately; praise of parent performance; and information statements about child management techniques, child development and child-rearing practices. The child behaviors recorded were compliance and noncompliance. The parent behaviors recorded were contingent attention to compliance (recorded only after a child had complied or had engaged in compliant behavior for 5 consecutive sec), attention to noncompliance (scored immediately following or simultaneously with noncompliance), instructions, and positive verbalizations. On most occasions, positive verbalizations also were scored as attention to compliance. (A complete set of behavioral definitions for trainee, parent, and child behaviors may be obtained from the first author.)

Trainee statements to the parent and child were recorded for the entire session, using a 10-sec interval method of recording. Parent and child interactions were recorded using the 10-sec interval method; however, parent-child interactions were scored only during the Instructional Training (IT), not before or after it. Trainee-parent interactions were sampled throughout the IT period and the long sequences before and after when the trainee was teaching or talking to the parent. The observers began their stopwatches as soon as all three people (trainee, parent, and child) were in the room, and stopped recording when the trainee left the clinic room to end the session. After the completion of each session, the trainee left the room and returned to the experimenter's office while the experimenter met the parent and child in the clinic room and walked them to the door. This restricted parent-trainee contact to the clinic room in which the observers could record their interactions, and thus prevented posttherapy sessions that might have taken place in the hallway, out of view of the observers.

Parent, child, and trainee behaviors were recorded simultaneously on a three-grid data sheet. The experimenter and one to three observers recorded through a one-way mirror. The observers, equipped with stopwatches, clipboards, and data sheets, sat at a counter in the observation booth

about 2 feet apart during the sessions. Initial sessions with each new trainee/parent/child triad were tape-recorded to identify and resolve any recording problems.

Interobserver agreement about the scoring of trainee, parent, and child behaviors was calculated by comparing the observers' data sheets, interval by interval. Interobserver agreement was scored if both observers recorded the same behavior in the same interval. Occurrence reliability was computed for all behaviors, and nonoccurrence reliability was computed for all behaviors that occurred in at least 50% of the intervals. Reliability observations on parent-child behaviors were obtained for 43 (47%) of the 91 observations. Reliability observations of trainee behaviors were obtained for 52 (57%) of the 91 sessions. At least one reliability observation was obtained in each experimental condition for each family and trainee.

Experimental Design and Conditions

A variation of the typical multiple-baseline design across the five triads (trainee/parent/child) was used. In the present design, data were not collected concurrently (i.e., at the same points in calendar time across subjects). Such a variation does not explicitly control for historical confounding. However, the likelihood that a relevant historical coincidence would occur on each of several baselines seems quite remote. Thus, the design implicitly controls for history by using a sufficient number of historically disparate baselines on which a consistent effect might be observed and replicated following intervention. In other respects, the design is equivalent to the typical multiple baseline across subjects in controlling for sources of confounding associated with the length of the baseline condition. The study was divided into three consecutive conditions: A parent-child baseline, a trainee baseline, and a training program.

Parent-Child baseline. After the first baseline session, the trainee began subsequent sessions merely by saying, "Let's get started" or "Let's put the toys away," and then observed the parent-

child interactions. Throughout the parent-child baseline period, the trainees made no recommendations to the parents about how to improve their children's compliance. However, the trainees were encouraged to talk to the parents and children; to ask questions about their families, activities, work, and interests; and to share aspects of their own lives and interests. They avoided only those topics regarding child development, child-rearing practices, and the like. If a parent asked for specific advice about a child-related topic, the trainee said, "I'm sorry. During this baseline period I cannot answer that question. However, I'll gladly answer it and other questions as soon as baseline is over." Because all participants had already been informed about the function of the baseline period, this questioning was an uncommon occurrence, and the trainees' refusal to answer was readily accepted by the parents.

Trainee baseline. In order to obtain a baseline of the trainees' behaviors, the experimenter, during this condition, told the trainees to begin offering assistance to the parents. The trainees were asked to call on their past experiences and training with people and to offer assistance as best they could to improve the parent-child interactions during the IT. Thus, the trainees were given permission to make any modifications to the clinic room and to conduct the sessions as though they were the only therapist working with the family. The experimenter made no evaluative comments about the trainee or parent-child performances during this condition, but instead, when in contact with the parent or trainee, chatted socially about topics unrelated to the study. If the trainees asked for advice or confirmation during this phase, the experimenter encouraged them to continue to use their own strategies to help the parents and acknowledged that the trainees might be feeling stress as a new parent trainer, but provided no other assistance.

Training program. For all triads, after parent, child, and trainee behaviors had stabilized during the trainee baseline, the experimenter began

the individual training of the trainee. The training was divided into two components: an initial training (divided into two 2-hr sessions) and feedback sessions before and after each session with the parent and child.

The initial 4-hr training period included a briefing session, introduction of the training manual, presentation of the videotaped models, and behavioral rehearsals.

During the initial briefing session, the experimenter summarized the progress of the study; described the parent, child, and trainee behaviors that were being observed; showed the individual graphic data of each trainee and of the parent-child dyad with whom the trainee was working; and began describing a behavior analysis approach to parent training. This approach included the definition, description, and measurement of behavior; the analysis of the functional antecedents and consequences of behavior; the use of reinforcement, extinction, and punishment; and the use of praise, planned ignoring, and time out.

The training manual gave trainees specific instructions and information about teaching parents to gain compliance from their children during the IT. Specific procedures (e.g., praise, planned ignoring, and time-out) were described, rationales for their use were provided, and a detailed description of how to teach the procedures to parents was outlined. Each trainee was asked to read the manual and answer the study questions at the end of each section before the next meeting.

The videotaped models showed the experimenter and two other parent trainers intervening with different families during the IT. The videotapes identified the important parent and child behaviors to respond to systematically, how to instruct and praise the parents, how to teach the behavioral procedures to the parents, how to time their comments correctly, and how to graph and summarize parent-child data before each session. In addition, the videotaped models prepared the trainees for a wide range of parent and child behaviors that might occur during

the intervention period but typically had not occurred during the two baseline conditions.

The experimenter, with the assistance of an observer playing the role of the child, rehearsed many of these skills (e.g., praise, planned ignoring, and time-out) with the trainee. The experimenter first modeled the procedures, and then had the trainee rehearse them. Once the trainee had learned the skills, the experimenter assumed the role of the parent, and had the trainee explain and teach the procedures to the "experimenter-parent." The experimenter provided continuous feedback until the trainee mastered the explanation, rationale, and demonstration of each skill.

After the initial 4-hr training period, all the trainees were given the book *Little People* (Christophersen, 1977) to read. This book was intended to assist parents with child-management problems; it provided the trainees with an overview of the breadth of problems parents encounter, and also offered effective solutions.

The second component of training was giving performance feedback to each trainee. Ten to fifteen minutes before each session, the experimenter and the trainee met to look at the graphed parent, child, and trainee data from the previous session, to discuss a plan of action for that day's session, and to answer any questions the trainee might have. As the trainee became more experienced, the experimenter prompted the trainee to devise and implement the plan for the day without experimenter assistance.

The postsession feedback period usually lasted from 10-15 min; it allowed the experimenter and trainee to summarize the session, discuss aspects of the trainee's feedback that had been effective or ineffective with the parent and child, propose alternative plans of action if necessary, identify other family problems that might require assistance (e.g., home problems such as toilet training, bedtime, and mealtime), and discuss other topics relevant to child development and parent training.

During the first intervention session, the trainee showed the parent graphs of parent-child

interactions during the IT, explained that a different intervention approach would be followed in the next sessions, and described, modeled, and role played the behavioral procedures with the parent. In addition, the parent was given two handouts to take home and study—one on differential attention and another on how to use time-out.

Training sessions continued until the parent and child (a) demonstrated clinically significant improvements over baseline levels of child compliance and noncompliance and parent attention to those child behaviors, (b) the trainee's rate of instructing/prompting the parent had declined to nearly zero, and (c) the parent was satisfied with the improvements in the child's behavior. Following the last session, the experimenter conducted the final interview with the parent and trainee.

RESULTS

Reliability

Trainee behaviors. Occurrence reliabilities for trainee behaviors are presented as the mean reliabilities for each behavior across all trainees and include instructions (range 86-100%), praise (range 83-100%), and information (range 88-92%). Nonoccurrence reliability estimates were not computed because during most sessions the individual trainee behaviors occurred in less than 50% of the intervals, making the occur-

rence reliability means the more meaningful estimates.

Parent-child behaviors. Occurrence and non-occurrence reliabilities of recording all parent and child behaviors are presented in Table 2. Again, these percentages represent mean reliabilities across all families for each condition. Occurrence reliabilities for all parent and child behaviors were 87% or greater; most mean reliabilities were equal to or greater than 90%. The nonoccurrence reliabilities ranged from 77% to 99%.

Trainee Behaviors

Instructions. During the parent-child baseline, when the trainees were asked to provide no assistance to the parents, their instructions were near zero as seen in Figure 1. During the trainee baseline, when the trainees were told to assist the parents in gaining compliance from their children, only Trainee 2 demonstrated an increase in instructions to the parent. However, Trainee 2 showed a marked decline in these instructions as the trainee baseline continued. With the introduction of the training program, all trainees, except Trainee 5, greatly increased their rates of instructing the parents. At termination, all trainees had reduced their rates of instructions to the parents to 5% or less.

Praise. Figure 2 shows that the trainees' praise statements to the parents, much like instructions, occurred in 5% of the intervals or less during the parent-child baseline and the trainee base-

Table 2
Occurrence/nonoccurrence reliability for parent and child behaviors by condition.

	Parent-Child Baseline	Trainee Baseline	Training Program	Mean Across Conditions
Occurrence/Nonoccurrence				
<i>Child:</i>				
Compliance	90/89	97/95	96/91	94/92
Noncompliance	94/77	96/85	92/85	94/83
<i>Parent Attention to:</i>				
Compliance	93/80	96/87	96/83	95/83
Noncompliance	98/86	96/86	87/—	96/86
Parental Instructions	98/99	95/95	94/90	95/94
Parental Praise	93/89	91/88	93/90	92/89

TRAINEE INSTRUCTIONS

Fig. 1. Percentage of intervals the five trainees instructed the parents during each experimental condition.

TRAINEE PRAISE

Fig. 2. Percentage of intervals the five trainees praised the parents during each experimental condition.

line, but increased to levels of 10%-15% during the training program condition.

Information. Figure 3 shows that information about child development, child management, and descriptions of and feedback on parent-child interactions comprised the largest percentages of statements the trainees made to the parents. In addition, increases in information statements during the trainee baseline were consistent across all trainees, with the exception of Trainee 3, who showed no change in information statements from the parent-child baseline to the trainee baseline. As with instructions and praise, information statements increased dramatically during the training period, ranging from 20% to 70%, and stayed relatively high throughout the final condition.

Parent-Child Behaviors

Child compliance and noncompliance. As seen in Figure 4, percentages of child compliance during the parent-child baseline were quite variable across the five children, ranging from a baseline mean of about 20% (Family B) to a high of approximately 75% (Family E). Percentages of noncompliance during the parent-child baseline were more similar across the children, varying from 70% (Family E) to 90% (Family B) with most of the children demonstrating mean percentages of noncompliance between 80% to 90%. (Because both child compliance and child noncompliance could be scored within a single 10-sec interval, the combined percentages of these two behaviors often summed to greater than 100%.)

When the trainees began assisting the parents during the trainee baseline, child compliance increased substantially only in Family A, while percentages of noncompliance remained unchanged or showed minor decreases for all children.

Improvements in compliance and decreases in noncompliance were apparent within the first three sessions during the training condition. The exception was one child (in Family A), who continued to display more noncompliance than

compliance for the first seven training sessions, and then showed a sudden reversal in these two behaviors (compliance increased to nearly 100% and noncompliance decreased to 20%) until termination. (See Discussion section for a more complete explanation of the problems in Family A.) For all the children, percentages of compliance ranged from 80% to 100% at termination; noncompliance ranged from 5% to 30% during the final sessions with each family.

Parent attention to compliance and noncompliance. Figure 4 illustrates that the percentages of parent attention to compliance during the parent-child baseline ranged from about 60% to 90% for all parents, with the exception of Family B, in which attention to compliance ranged from 10% to 45%. During the trainee baseline and training program conditions, parent attention to compliance changed very little for most parents, with the exception of the parent in Family B. This parent showed marked increases in her attention to compliance during the last two sessions of the trainee baseline (increasing from 30% to 80%). This improvement was the apparent result of the trainee instructing the mother to guide the child physically through the task, a procedure not used in the earlier sessions. For all families, there were only modest increases in parent attention to compliance from the trainee baseline to the training program condition.

Parent attention to noncompliance during the initial condition ranged from 60% to 100% across the five parents. Parent attention to noncompliance did not change appreciably, in four of the five families, from the parent-child baseline to the trainee baseline. In Family D, the parent's level of attention to noncompliance dropped during the first two sessions of the trainee baseline, and then returned to its previous high level by the end of this condition.

All five parents showed immediate reductions in their attention to noncompliance with the onset of the training program condition. Their attention to noncompliance continued to drop throughout the remainder of the study.

TRAINEE INFORMATION

Fig. 3. Percentage of intervals the five trainees informed the parents about child-related topics during each experimental condition.

CHILD COMPLIANCE/NONCOMPLIANCE AND PARENT ATTENTION TO BOTH

Fig. 4. Percentage of intervals of child compliance/noncompliance and parent attention to these child behaviors for all five families during each experimental condition.

A second measure of parent attention to compliance was the number of positive statements the parents made to their children. Four of the five parents had low rates of praising their children during the parent-child baseline, ranging from 0.5 to 2.0 per min. The parent of Family E demonstrated unusually high levels of praise, averaging about 3.0 per min during the parent-child baseline and the trainee baseline. With the onset of the training condition, all five parents increased their praise statements by 150% to 400%.

DISCUSSION

This study documented the effectiveness of a training program in teaching behavioral procedures and skills to therapist trainees who were, in turn, able to teach those behavioral procedures to parents and to produce improvements in parent-child interactions during a compliance task. The study also examined the occurrence of particular therapist behaviors—instructing, informing, praising—as they corresponded to improvements in parent-child interactions.

In general, the trainees' largely ineffective methods of intervention during the trainee baseline were to inform parents about child development, child management, or related topics. They were essentially nondirective, and they produced negligible changes in parent/child behaviors. It was only after training that their rates of relevant instructions, praise, and information increased, accompanying improvements in parent-child interactions. In four cases, concurrent increases in all three of these trainee behaviors accompanied parent/child improvement; for Trainee 5, increased rates of praise and information without increased instruction giving accompanied dramatic parent/child improvements. The experimenter later discovered that the parent in this triad had worked as a teacher in an institution for the mentally retarded, and had learned there to apply many behavioral procedures in her interactions with handicapped children. Interestingly, this parent

had failed to generalize the use of the procedures to her interactions with her own child. However, when she was informed about the utility of these procedures with normal children, she readily and consistently applied them in her interactions with her son, without requiring specific instructions in how to use them.

From the results of this study, the separate function of these three trainee behaviors in leading to positive change in the families cannot be determined. However, informal comments from the parents during the final interviews suggest that there may be a hierarchy of importance. (1) For the most part, the parents reacted positively to the information by the trainees and frequently asked the trainees questions to gain additional information. (2) Some of the parents initially expressed discomfort and embarrassment with the trainees' praise of their performance. Upon questioning by the trainee, all parents agreed praise was an important means of feedback and that it provided them with a valuable model. (3) The parents said they felt the most anxiety when the trainees instructed them to interact in a specific manner with their child, but found that their anxiety diminished as they effected improvements in their child's behavior and the number of trainee instructions dropped. Thus, the parents seemed subjectively to feel most comfortable with trainee information, then praise, then instructions.

An important part of the training was to teach the trainees to attend closely to parents' verbal and nonverbal behaviors, and to adjust accordingly the timing, tone, and content of their own comments. After the trainees became more skillful at interacting with the parents, a fairly regular pattern developed in their verbal interactions. This pattern included the trainee's identification of a child behavior (information), followed by an instruction in how to increase/decrease the behavior (e.g., by ignoring or praising), then a rationale for the instruction (information), praise for the parent's correct response, and finally, a rationale for the trainer's

praise (information). Thus, the pattern looked like this: information—instruction—rationale (for the instruction)—praise—rationale (for the praise).

By frequently providing rationales to the parents, it is possible that the trainees were able to provide more effective training because they had learned, through shaping from the parents and the experimenter, how to present the information to produce maximum improvements. The patterning or sequencing of therapist comments may be an important area for future analysis.

An important question that arises in evaluating any training program involves the generalization of the program (a) in training a variety of people (in this case parent trainers) and (b) in effecting change with a variety of clients. The trainees in this study were chosen, in part, because of their diverse backgrounds and experiences in working with children and families. This diversity in experience and theoretical backgrounds made little, if any, difference in the trainees' abilities to learn the skills or to teach them to the parents. This encourages application of the training program to still other professionals and paraprofessionals who deal with families of young problem children (e.g., public health workers, day-care personnel, volunteer counselors, and lay therapists).

Diversity was also found in the backgrounds and developmental levels of the parents and children. Even children with severe developmental delays, as in Families A, B, and C, benefited from the training. For one family, Family A, the effects of the training were delayed because the extent of their child's hearing loss was not known until after the first five training sessions (results of a hearing evaluation indicated fluid in both ears), at which time a strategy of pointing to each toy and container (while stating the instruction) and physically reinforcing compliance (e.g., with hugs) was developed to ensure that the child understood what was expected. Once the hearing loss was confirmed and the additional "signing" procedures were

implemented, there were rapid improvements in the child's behavior. Thus, the training program was found to be effective in changing the behaviors of both normal and handicapped children and the behaviors of their parents, further enhancing its broad utility.

Future research should address the question of generalization. Training of parent trainers that is conducted in the clinic should be tested in the home to assess generalization of the trainee's therapeutic skills and parent/child behaviors (a) across settings for the specific task that was trained (e.g., the Instructional Training task), and (b) across behaviors for other parent-child interactions (e.g., dressing, eating, and toileting). Trainees could also be tested for their generalized use of skills across families by having the trainees intervene with several other families with different presenting problems.

The identification of other critical therapist behaviors is another area for future investigation. Informal observations in this study suggest that additional data on at least three other categories of trainee behaviors—information gathering (questions to parents about child-related topics), rationales about therapeutic procedures or practices, and relationship building (statements aimed at developing an effective therapeutic relationship)—could provide important information about the trainee's therapeutic skills and might add to the efficacy of the training program.

Experimental investigations that focus on the training of family therapists have just begun. Because of the needs that exist for more specific skill training in supervised clinical settings (Bouchard *et al.*, 1980; Quilitch *et al.*, 1975) and for the development and documentation of effective training programs (Garfield, 1977; Matarazzo, 1971), therapist training is a fruitful area for additional research.

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