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TRAINING PARAPROFESSIONALS FOR A DEVELOPMENTAL WARMLINE: A COMPARISON OF TRAINING EFFICACY

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TRAINING PARAPROFESSIONALS FOR A DEVELOPMENTAL WARMLINE: A COMPARISON OF TRAINING EFFICACY

By

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ABSTRACT

TRAINING PARAPROFESSIONALS FOR A
DEVELOPMENTAL WARMLINE:
A COMPARISON OF TRAINING EFFICACY

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In this study, evaluation was made of a training program for paraprofessionals interested in working on the Parentline, a warmline educational/management and referral service for parents. Three groups were trained, a graduate full-training group, an undergraduate full training group, and an undergraduate partial training (experiential) group. Thus, both training modality and academic status of subjects were compared for their effects upon paraprofessional effectiveness.

The three groups were evaluated on five areas thought to be important to adequate performance on the Parentline: knowledge of child development, knowledge of parenting skills, empathy, assessment skills, and sensitivity to

children. Measures utilized were the Child Development Questionnaire, Parenting Skills Questionnaire, ratings of role plays, and the Sensitivity to Children protocol. Results were compared to criterion scores derived from the performance of trained, experienced Parentline staffers. Reliabilities were found to be adequate except for the Child Development Questionnaire.

Results indicated that the training program was adequate to train graduate students, six of ten reaching criteria on all post-training scores. One of ten full training undergraduate students, and one of ten partial training undergraduate students also passed on all scores. Of the twenty undergraduate students, however, nine missed reaching all criteria by just one measure.

While the results indicated that paraprofessionals can be trained to provide adequate service by means of the training program, several implications for further consideration were found. A revised measure of child development knowledge was thought to be needed. The necessity of providing remedial training for undergraduate students was apparent.

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So this time has come at last. How many images and memories rush in while writing this! Remembrances of the past eight years since entering graduate school, and of the past several decades of being. Well, there's no point in mentioning the thoughts - we retain our past within and it is revealed by how we choose to live.

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CHAPTER ONE

Literature Review

The purpose of this study was to provide a standardized training manual and pre- and post-training administered measures designed to evaluate the effects of training paraprofessionals and their ability to provide competent service in terms of quality of problem assessment, use of accurate empathy, knowledge of basic child development, knowledge of parenting techniques, and sensitivity to the needs of children. As will be demonstrated below, there is an increasing need for services that can provide information to parents who are experiencing difficulties with their children. There is a parallel need for evaluation of such programs. Relevant areas of interest that will be considered in this review of the literature are:

1. Crisis: definition and intervention
2. The increase in crisis intervention programs over the past several decades
3. Explanation of and rationale for a Parentline-type service
4. The utility of attempting to train parents to alter their children's behaviors
5. The use of paraprofessionals in the mental

health field

Crisis: Definition and Intervention

Crisis intervention is not a term which has enjoyed consistency of connotation. It has sometimes been construed with wide latitude.

> In the broadest sense, the origins of crisis intervention date from man's earliest days. The first time one person came to another with a problem and was met with some degree of understanding, support, and active assistance rather than being attacked for being weak, crisis intervention was born. (Wicks, 1978, p. 1)

This definition would clearly include everything from resisting the temptation to brain a sick cavemate to the food stamp program.

A definition with somewhat decreased catholicity is offered by Howard Parad:

> Crisis intervention means entering into the life situation of an individual, family, or group to alleviate the impact of a crisis-inducing stress in order to help mobilize resources...[with] the dual objective of (1) reducing, whenever possible, the impact of the stressful event, and (2) utilizing the crisis situation to help those affected not only to solve present problems but also to become strengthened in mastering future vicissitudes by the use of more

> effective adaptive and coping mechanisms. (Parad, 1965, p. 2)

It might not be amiss to consider the characteristics of a crisis, of what it is comprised, by what it is engendered, and the nature of its effects, before attempting to settle upon a useful definition of crisis intervention.

It is helpful to consider individuals and systems as being essentially homeostatic. The term is used in biology to define the tendency of a body to establish and to maintain a utile and advantageous physiological equilibrium. Use of the term has been extended to include an organism's or a system's emotional equilibrium. Otherwise expressed, both in individuals and among groups of people, there will always be a variety of needs that will seemingly or actually be in conflict. The individual and the system both reach states of equilibrium based upon striking the most functional compromise possible among conflicting needs.

Crisis has been defined as:

> The experience of one or more people who have a problem or conflict that they cannot immediately solve. "Going to the refrigerator one night I found myself unable to decide whether I'd like an orange or a bowl of ice cream." (Gaffney, 1978, p. 8)

This definition however blurs the essence of a crisis through its failure to include all three of the components

of a crisis. A considerably more useful definition of a crisis encompasses the three parts which are: an event or a conjunction of occurrences, a response to the events that is painful or dysfunctional, and the inability of old patterns of behaviors to overcome the new problems concomitant with an inability of the individual or system to muster the resources to create new successful behaviors.

We see then, that in a crisis the homeostasis of the organism founders, and the organism is unable to successfully achieve new compromises among conflicting needs and desires and thus remains for a time in a painful state of disequilibrium.

A precipitating event might be a catastrophic external occurrence, for example, the death of a loved one, a war, or a flood. Equally the crisis can be engendered by common life tasks.

> A maturational crisis is a conflict encountered by many individuals as they progress through the normal process of biological, social and emotional development...the most likely times for these crises to occur are during normal biological periods of growth when the expected social and emotional changes corresponding to these periods are experienced as too conflicting or threatening for adequate integration into the existing personality. (Polin, 1978, p. 35)

Crises occur in the lives of us all. Some events are consensually defined in our society as especially stressful, or painful, events. An example is the death of a spouse or of a parent. Other events are not so widely believed to be inherently as stressful. Getting a B on an important Russian History exam may be an example for some students. Nevertheless, a crisis may develop after receiving this grade. While a crisis may be precipitated by an event, it is not caused by the event. Rather, it is due to the meaning which the event holds for an individual or a system. Even as the savoring of a madeleine was sufficient, in Proust's Swann's Way, to flood Swann's mind with the fragrance and memories of his childhood, and the unremembered but well-preserved emotions of that youthful period, so situations, changes, events, can and do have connotations for us far beyond their literal presence and bring to light a congeries of conflicting thoughts, feelings, and beliefs that might have lain gathering dust in the mind's attic for years.

These are the first two legs upon which the definition of a crisis stands, occurrences and responses to them that are painful or dysfunctional. Only the third component is now necessary for a crisis to develop. The resources available to the individual or system, must be insufficient to allow for confrontation with and successful resolution of

these new conflicting feelings or problems.

Crises exist. Inherently, while painful, they are neither good nor bad. They present opportunities which can be seized upon to lead to growth, equilibrium on a more satisfying and constructive level, and increased flexibility. Conversely, crises can lead to greater rigidity and dysfunctional protective attempts at problem resolution. Opportunities for achieving new, more adaptive functioning they are, however, and as such are often ripe for useful intervention. J.K. Morrice (1976, p. 4) states that:

> The optimistic message conveyed by practitioners of crisis intervention is that we are not necessarily the prisoners of our immutable personalities. We can learn to make wiser, healthier, and more responsible choices at critical periods of our lives. But often we need support and help to do so successfully.

The importance of crisis intervention has indeed been stressed for over four decades. Lindemann (1944) addressed himself to crises arising from actual or anticipated deaths and the difficulties that occur in successfully managing the grief reactions. Furthering the call for making crisis intervention a strong weapon in the mental health armamentarium has been Lydia Rapoport (1967, p. 39) who states that:

> The person or family in crisis becomes more susceptible to the influence of `significant others' in the environment. Moreover, the degree of activity of the helping person does not have to be high. A little help, rationally directed and purposefully focussed at a strategic time is more effective than more extensive help given at a period of less emotional accessibility.

To return then to our attempt to define crisis intervention, Parad's (1965, p. 2) statement comes into focus. Crisis intervention "means entering into the life situation...[rationally and purposefully]" to mitigate the stressful quality of the precipitating event (in order to allow for mobilization of resources) and to help the individual or system learn new adaptive coping behaviors as a result of the crisis.

What are some of the characteristics of crisis intervention that make hotlines, warmlines (which are phone services that are designed to respond to problems that are not emergencies), and the use of paraprofessionals a feasible and perhaps preferred modality? As stated by Caplan (1964, p. 43)

> It is necessary to take into account not only the person himself, but also the realities of his milieu and his interplay with other people, so in discussing

> crisis resolution, we must place great emphasis on this play of forces. A man does not usually face crisis alone, but is helped or hindered by the people around him, by his family, his friends, neighborhood, community, and even nation.

Furthermore, the first helpers sought, the gatekeepers in the community, are rarely if ever professional mental health workers. They are community persons who by dint of position, personality, or propinquity, are amenable to approach. These individuals range from physicians to religious leaders, from nurses to bartenders, from teachers to friends. These individuals are often likely to be closer in cultural outlook to the concerned person, and may frequently be, despite lack of training, empathic and wise. The importance of training and utilizing this vast resource was stressed by Caplan (1964).

Increased Frequency of Crisis Intervention Programs

In the last thirty years or so there has been a significant increase in both the number and the type of crisis intervention programs. There are now drop-in centers at many universities, drug abuse hotlines, child abuse hotlines, twenty-four hour crisis lines and a host of other services.

The best documented history of the development of a type of crisis service is that of suicide prevention

programs, so let us briefly consider their development as an indication of the more general increase in intervention services. In 1906 the National Save-a-Life-League was created. Among other services, they established a 24 hour crisis telephone line. Fifty one years later

> Of 2202 entries in the 1897 to 1957 section of the Bibliography [The Bibliography on Suicide and Suicide Prevention - Farberow (1968)], only three are indexed under the heading of 'prevention services, center.' (Mcgee, 1974, p. 54)

In 1958 the Los Angeles Suicide Prevention Center was established. Since then the number of such centers has increased from one or two in 1971, to over 185 as indexed in the Directory of Suicide Prevention/Crisis Intervention Agencies in the U.S. (American Association of Suicidology, 1977).

What might account for this great proliferation of intervention services during the past three decades? There is a confluence of several developments that may be seen to have fostered this increase. The first has to do with economic and social developments across the country. As brilliantly foreseen by Thomas Hobbes (1651) in Leviathan, capitalism in its highest expression demands that its members view themselves primarily as homo economicus - that they view themselves primarily in terms of their labor

functions and less so as family members, community members, church members, and class members (of course). This enables the economy to operate as freely as possible, with a labor force willing to relocate wherever their jobs may take them. Whatever the causes, increased mobility has become the rule over the past few decades. In 1950, according to federal census data, under 20% of the total population changed residence. In 1970 this percentage had risen to almost 50%. Of these, over 16,000,000 people moved to a new state and over 10,000,000 moved to a non-contiguous state.

Another trend has been toward decreasing percentages of three and four generation households. In 1960, there were 2,333,124 households that included one or more parents of the head of household or spouse; 1,434,077 included grandchildren of the head of household or spouse; 51,638 households included both. Ten years later the number of households had increased by approximately 20% yet the number of households with three or more generations had actually decreased.

Also by census data there has been a hefty increase across the board of number of children living in households with only one parent either due to death of a spouse or divorce, or being raised by a single parent. This increase is even more noteworthy when considered against the backdrop of the decreased mortality and birth rates. The picture

being drawn is one in which an increasing portion of our society is living with decreased access to some of the traditional resources upon which to rely during crises - community, family, and friends.

Along with this trend, has come a tremendous increase in public monies being spent for social welfare programs. This trend began under President Franklin Roosevelt in some of the economic reforms he hoped would ameliorate a few of the greater excesses in human misery brought about during the great depression. It reached a peak in the early sixties when the vision of the "great society" was promulgated and when in the mental health field, Community Mental Health Centers were proposed.

A third development no less important than the other two, whether caused by increased needs or other factors, is the movement to utilize paraprofessionals in an increasing number of ways and in increasing numbers. This has enabled the field to attempt to meet the great shortage of personpower noted by the Joint Commission on Mental Illness and Health (1961).

> In its report, the Commission called attention to the unrelenting manpower shortage, and it advanced the idea of the 'mental health counselor with access to consultation' as the solution to the increasing lack of traditional professional personnel. (Mcgee, 1974, p.6)

Ways in which paraprofessionals have been utilized will be discussed later in this review.

Explanation of and Rationale for Parentline

Reflecting upon the previous section with its depiction of present day American society characterized by weakened supports for families, noting the concomitant increase of a variety of stressors (drugs, unemployment, etc.), noting too the often decried personpower shortage in the mental health field (Graziano, 1969, 1975, 1977; Joint Commission on Mental Illness and Health, 1961; O'Dell, 1974), we are struck by the need for parsimonious, effective and inexpensive services that buttress these families which are experiencing difficulties with limited resources.

As suggested too in the previous section, diverse telephone emergency services have been developed that begin to address the problems. Typically these are twenty-four hour "hotlines" which offer either specialized help (runaway, drug abuse, suicide) or broad band services. Services are provided, generally through empathic listening, referrals to appropriate agencies, or the actual arrangement of emergency care.

Essential characteristics of the Parentline service overlap greatly with these hotlines. In such a program empathic listening, support, referrals and emergency help are important aspects of the services offered. A

Parentline, however, is not directed toward emergencies and traumas, but rather to those hypothesized group of families in which problems are exacerbated by lack of parent training, knowledge and supports, and in which pain and doubt, in varying degrees and with varying degrees of permanence are present. These are families for whom education - about the normality of familial behaviors, about sound parenting techniques, about the acceptability of familial reactions to each other - might help to prevent the development of more intractable problems and of more severe emergencies, demanding as they would more intensive and expensive utilization of professional time.

Reduced to basics, then, the Parentline is a "warmline". Unlike "hotlines", which tend to be 24 hour a day emergency services, a warmline is staffed for several hours a day, with technology available other hours for people to leave messages. Several interventions are offered; information about child development, education about effective parenting techniques, consultation about the parents' attempts to solve a problem, and referral to appropriate agencies. These interventions are embedded in an interpersonal context of warmth, support, and competence.

It follows that staff members need to be skilled in a variety of efforts. These include how to assess a problem, how to assess amenability to the effectance of change over

the phone, how to select among interventions, and how to conduct a call in an effective and supportive fashion.

Utility of Training Parents to Act as Change Agents

It is all well and good to promote the claims in the previous section that through sagacious use of paraprofessionals we can minimize problems and forestall or eliminate the need for more intensive and expensive use of professional time, but is there any reason to suspect that these assertions are true?

There is an increasing body of literature on training parents to act as change agents for their children. Perhaps the first reference, surprisingly enough, belongs to Sigmund Freud for his work with Little Hans (Freud, 1909) which was completed without Freud ever seeing the youngster, but providing therapy instead through his father. Among psychoanalysts Kubie (1937) similarly treated a phobic child through a parent.

Guerney (1969) and Moustakas (1959) also treated children by means of their parents but without doubt the bulk of research utilizing parents involves the use of operant conditioning techniques. What is perhaps the pioneering work involving the use of such behavioral management techniques with parents is that of Williams (1959) who taught parents how to respond to their twenty-one month old child's screaming at bedtime - namely to ignore

it. In this case success was reported with no recrudescences during a two year follow-up period.

Since this time the number of parent training and parent education programs has increased greatly and they have addressed an increasingly wide range of problems in terms of both complexity and severity. As O'Dell (1974) suggested, there does not appear to be any class of overt child behavior that parents cannot be trained to modify.

For purposes relevant to this study, two areas will be considered in some detail. These areas, which are common concerns for callers to a Parentline type of service (Derita, 1976), are noncompliance and aggression. Before examining these however, let us briefly peruse the breadth of areas shown to be amenable to change through the use of parents as paraprofessionals.

Several studies considered body waste problems. Tough, Hawkins, McArthur, and Ravenswaay (1971) taught parents to use aversive conditioning to eliminate nocturnal enuresis in youngsters. This was successful as long as the contingencies remained in place. Paschalis, Kimmel and Kimmel (1972) taught parents to treat their children who were nocturnally enuretic by using rewards for prolonged retention by the children during the daytime. Other researchers have used parents to successfully treat encopresis (Conger, 1970) and constipation

(Lal & Lindsley, 1965) by means of altering reinforcers.

Some studies have considered the parents' ability to decrease their children's fears. School phobias (Kennedy, 1965), fear of water (Bentler, 1962) and fear of noises (Tasto, 1969) are several such. Thumbsucking (Knight & McKenzie, 1974) and asthma (Neisworth & Moore, 1972) are two other areas covered. Parents have been used as adjuncts in treatment of other phobias (Weber, 1939), eating problems (Bernal, 1973), elective mutism (Wolhert, Nyman, Snow & Owen, 1973), and self-destructive behaviors (Allen & Harris, 1966).

Noncompliance

Noncompliance, which is the refusal or failure to obey parents' commands, abounds in normal children as well as in "deviant" children. It has been reported that normal children (Johnson, Wahl, Martin, & Johansson, 1973) comply only 75% of their opportunities to do so. Other estimates of noncompliance rates for normal children have ranged from 15% (Piat, Sadler, & Vickers, 1973) to 38% (Johnson & Lobitz, 1974). It has been found however that deviant or clinic referred children can be differentiated from non-referred children by the percentage of their noncompliant responses to commands. Forehand and King (1977) have reported estimates (for clinic referred children) at more than twice the 25% noncompliance figure.

Green, Forehand, and McMahon (1979) and Forehand, King, Peed, and Yoder (1977) have reported similar findings.

Programs that investigate compliance among normal and clinic referred children consider, as well, another stratum of concerns. Besides the frequency of deviant child behaviors is the possibility that the problem may be the result of inappropriate parental expectations, attitudes, behaviors, or levels of anxiety.

In fact, degree of noncompliance in a laboratory setting is not the only nor necessarily the best predictor of referral to a clinic or of noncompliance in the home. Forehand, Wells, and Sturges (1978) found that two maternal behaviors were the best predictors of noncompliance in the home; beta comands (commands that are not followed by an opportunity for the child to demonstrate compliance) and total rewards. The presence of high numbers of the first or low numbers of the second surpassed in predictive value for noncompliance both questionnaires responded to by the parents, and observed child behaviors in the laboratory setting. Forehand et al. (1977), mentioned previously, also found that mothers' use of beta commands and criticisms differentiated between normal and clinic referred children.

What are the implications of these findings? If parental behaviors differentiate between clinic and normal populations (and especially if deviant child behaviors are

correlated with parental behaviors) the approach of training parents appears to be theoretically viable. Several questions are generated by this direction. Do parents know how to act in order to achieve desired ends yet fail to consistently perform for other reasons, or are they insufficiently aware of the relationships between their behaviors and those which are elicited by them?

Several studies suggest that parents can, in fact, alter the quantity of compliant and noncompliant behaviors of their child by changing their own behaviors; specifically by utilizing more suggestions and concrete commands and rewards, and fewer vague commands and disapproving comments. Johnson and Lobitz (1974) and Lobitz and Johnson (1975) reported that parents of both deviant and normal children were able to increase and decrease the total deviant behaviors of their children when instructed to make them "look good" or "look bad." Green et al. (1979) expanded upon this work and found again, that mothers of both normal and deviant children were able to manipulate their children to display greater or less compliance.

Inferences from such investigations have implications for parent training programs. Frequently what may be necessary is not to provide skill training, but to address the reasons that parents are failing to consistently utilize the knowledge they already have about their children's

behaviors. Several reasons occur. One is that parental expectations are such that the child ought to obey regardless of how the suggestion is made - simply because the parent is the parent and the child is the child. Another reason is that parents are in stressful relationships with each other, or at work, or at the unemployment office. It has been shown by Lytton and Zwirner (1975) both that suggestions are effective in engendering compliance, and that suggestions tend to be used primarily when conflict is limited or non-existent.

Two additional reasons for the success in training parents then come to mind. One is that in so doing, parents' confidence in themselves and in their capabilities is bolstered, their sense of helplessness vitiated. Hence situations as they arise are more likely to be responded to out of a feeling of mastery, conflict is lessened and the use of compliance engendering behaviors further increased, as a feedback loop.

A second reason involves attitudinal changes. Besides parents learning that their expectations were excessive and scaling them down, by virtue of observing and counting noncompliant behaviors it is not uncommon for the behaviors to decrease or to be discovered to be less frequent than originally thought. The resultant change in parental attitudes toward the child can foster more approving

behaviors and decreased noncompliance (Lobitz & Johnson, 1975). As parental understanding of the links between their contingencies for the children and the children's behavior is strengthened, as children's outbursts can be seen less as vaguely comprehended malevolent or compulsive conduct like the monthly ravages of a lycanthrope, parental attitudes, skills, and expectations can work toward a more functional and harmonious existence.

Aggression

A variety of studies have considered the viability of training parents to decrease the aggressive behaviors, which consist of threatening or physical assaults, of their children. One program that has spawned much research is that reported by Patterson, Ray, and Shaw (1965) and Patterson, Cobb, and Ray (1972). This program involves training in behavioral observation and the collection of baseline data, training in principles of operant conditioning, a weekly group for couples, individual meetings to devise individualized training plans and daily telephone contact. Wiltz (1969) demonstrated that the program was successful in decreasing the aggressiveness of boys. Walter and Gilmore (1973) replicated this finding in a study that controlled for status attention and attention effects. Patterson et al. (1972) reported similarly positive data.

Other studies have utilized a somewhat different approach in training parents. These include direct observation of the target child in interaction with a parent(s) and frequently they involve cueing the parent to demonstrate one of several previously delineated responses to the child. Lavigueur, Peterson, Sheese, and Peterson (1973) reported success using this latter device.

A case study has been reported by Bernal, Duryee, Pruett, and Burns (1968) which involved a program designed to aid a mother in controlling her eight and a half year old son. The boy was physically and verbally abusive to his mother and to peers, as well as demonstrating a range of symptoms of serious emotional difficulties. This program utilized social learning theory principles, videotaped interactions for ongoing feedback and the use of tones over an intercom as stimuli for the mother to initiate one of a variety of responses, such as ignoring, to her son's behaviors. Bernal et al. (1968) reported success that remained evident after follow-up five months later.

Hawkins, Peterson, Schweid, and Bijou (1966) carried out an in-home treatment program for an aggressive four year old boy. Extensive baseline data were collected by trained observers. Following this, the boy's mother was told of nine unacceptable behaviors to which she was expected to respond in one of three ways; informing the boy to cease the

behavior, putting him in timeout, extending social reinforcers. She was cued as to which to choose by three gestures made by the present observers. Utilizing an A-B-A-B pattern of interventions, Hawkins et al. (1966) showed impressive changes after just a three week experimental period and maintained these changes at a follow up period some months later (the exact time of the follow up was not reported).

Holland (1969) reported a case study in which the parents of a seven year old with a serious and long-standing (two year) fire-setting habit were seen five times individually by the therapist for a group in which they were members. A program involved choice of effective discipline (loss of prized baseball glove), clarifying the target behaviors as discriminative stimuli for the discipline, and reinforcement of socially acceptable behavioral options when in the presence of matches. After five weeks (the first two spent developing the program) the problem behaviors were reported to have been entirely eliminated.

Certainly these studies, both case studies and those involving experimental manipulation of groups, seem to suggest that parents can be trained to alter the behaviors of their children even when the behaviors are serious and long-standing, and when the training involves simply devising and implementing a behavioral program.

The Use of Paraprofessionals in the Mental Health Field

As utilization of paraprofessionals has intensified, various studies have considered their effectiveness in a number of different roles. Researchers such as O'Dell (1974), Johnson and Katz (1973), and Berkowitz and Graziano (1972) all support the belief that paraprofessionals (specifically parents in the above examples) can offer effective and valuable services.

Paraprofessionals' performances have been demonstrated to be at least equivalent to professionals' in counseling or psychotherapy roles with children (Karlsruher, 1976), with outpatients (Magoon & Golann, 1966; Weinman, Kleiner, Yu, & Tillson, 1974), with inpatients (Jensen, 1961; Mosher, Menn, & Matthews, 1975; Poser, 1966), and with college students (Zunker & Brown, 1966). They have been used to treat insomnia (Lick & Heffler, 1977), enuresis (Werry & Cohrssen, 1965) and shyness (Kazdin, 1975). A recent meta-analysis of past comparisons (Hattie, Sharpley, & Rogers, 1984) supported Durlak's (1979) review of the literature in which the comparative or greater efficacy of paraprofessionals was suggested. This study concludes that the weight of past published research is in fact in favor of comparative effectiveness of paraprofessionals. The comparative value of paraprofessionals is also supported by Berman and Norton (1985).

Paraprofessionals have also been used extensively in crisis intervention programs. Most reported results are favorable to their efforts. While Carothers and Inslee (1974) and Genthner (1974) failed to find a satisfactory level of functioning by paraprofessionals on hotlines, De Vol (1976), Derita (1976), Getz, Fujita, and Allen (1975), Knickerbocker and McGee (1973), Morgan and King (1975), and Rosenbaum and Calhoun (1977) found that paraprofessionals performed adequately on similar services. In fact, in a study, Durlak (1979), that reviewed the results of forty-two studies each of which compared the efforts of paraprofessionals of different descriptions with the efforts of professionals, the results were quite noteworthy. Overall, paraprofessionals were found to be as effective in 29 studies, more effective in 12, and less effective in one. More specifically in the five studies included that bear directly upon skills and problems relevant to a Parentline service, three [Knickerbocker & McGee, 1973 (crisis intervention); Leon & Mandell, 1966 (enuresis); and Werry & Cohrssen, 1966 (enuresis)] favored paraprofessionals and two [De Vol, 1976; and Getz, Fujita, & Allen, 1975 (crisis intervention)] favored neither group.

Explanations are tentative as to why paraprofessionals have demonstrated comparable effectiveness to therapists (Carkhuff & Truax, 1965; Balch & Solomon, 1976; Karlsruher,

1974; Miller, 1978). They seem particularly qualified to perform activities that entail empathic listening listening (Knickerbocker & McGee, 1973; Truax, 1973) and the carrying out of detailed and well specified activities (Durlak, 1979).

Statement of the Problem

It has been suggested (Cowen & Zax, 1967) that instead of expanding traditional psychotherapeutic services, educational programs to teach problem solving skills would be effective and an efficient use of money and time. It has further been suggested that paraprofessionals are as effective or more effective than professionals in a wide range of service roles (Durlak, 1979) with professionals having particular difficulties relating to and communicating with low SES clients (Gladwein, 1968; Reiff, 1967).

Accordingly, a new type of telephone service has been developed using paraprofessionals to provide parents with education about child development, education about parenting techniques, assessment of problems, consultation, support, and referrals. An example of this service is the Parentline at the Michigan State University Psychological Clinic. This service demands that staffers be knowledgeable in the areas of empathic responding, how to assess problems, normal child development, and parenting skills. As France (1975) has noted, frequently there is no empirical evaluation of staffers in these areas. Indeed, as Schinke, Smith, Myers, and Altman (1979, p.22) state, "despite increased reliance on paraprofessional crisis interventionists, few training models are published ...[and] even fewer are attempts to evaluate crisis-intervention training."

Particularly since paraprofessionals have not previously been used to provide the range of services offered in a Parentline, evaluation is critical. This study will evaluate several training modalities, and consider the reliability of several measures in ascertaining subjects' competence in the areas of quality of assessment skills, use of accurate empathy, knowledge of basic child development, knowledge of parenting techniques, and sensitivity to the needs of children.

Research questions center around one basic consideration: whether paraprofessionals can be trained utilizing a particular training package to perform adequately on a service such as Parentline. In order to assess this, several factors must be delineated. One factor is the definition of skills inherent in performance. A second factor is to devise means for evaluating trainees' behaviors in the selected areas. A third factor is the development of criterion levels that characterize adequate performance. A fourth factor is the comparison of several training models in order to assess their relative efficacy. The fifth factor is to assess whether academic level (e.g., graduate vs. undergraduate status) differentiates between successful and unsuccessful candidates for training.

CHAPTER 2

Method

Subjects

Subjects consisted of ten graduate students and twenty undergraduate volunteers. Demographic characteristics of the research population, research group membership, and their levels of experience with children are shown in Table 1. Graduate students were all part of the Clinical Psychology Department of Michigan State University. Academic status ranged from first year to fourth year students. Six were students in the Child and Family Program at M.S.U., and four were students in the Adult Program. Eligibility for subsequent placement on the staff of the Michigan State University Parentline was made contingent on participation in the training program.

Of the undergraduates, seven in each group were psychology majors. All were either seniors or juniors.

Undergraduates enrolled in a course entitled "Introduction to Helping Families and Children"; participation in the research training program was required for receiving course credit. Other criteria for receiving credit for this course were consistent attendance, and a report written upon a mutually agreed upon topic of

TABLE 1

Demographic Characteristics of Subject Population by Group

Group	Mean age	Sex	Mean experience (a)
Graduate	28.7	F=8 M=2	2.3
UGFT (b)	23.2	F=7 M=3	1.5
UGPT (c)	25.4	F=9 M=1	1.8

(a) Experience with children, self-reported on a 5 point scale wherein 1 = no experience and 5 = extensive experience

(b) UGFT refers to the undergraduate full-training group

(c) UGPT refers to the undergraduate partial-training group

relevance. Undergraduates participated with the knowledge that depending upon their performance during training, they might be eligible for working on the Parentline after the training was completed.

Procedure

Subjects were divided into three groups. The ten graduate students were assigned to one group. The other two groups consisted of ten undergraduates each. These undergraduates were given a choice of two times for training, and were assigned to their respective groups according to their choice.

At each first group meeting, all subjects were given a packet which included the following: a consent form, a background information sheet, instructions for filling out all forms, the Sensitivity to Children Scale (STC), the Child Development Questionnaire (CDQ), and the Parenting Skills Questionnaire (PSQ). At this meeting, the consent form was read, signed, and collected. Instructions for all of the forms were read and questions were answered. Subjects completed the three measures and the background information sheet individually by the beginning of the first training session which occurred the following week. All forms were collected at the beginning of this meeting.

In addition, during the first meeting, the procedure

for assessing pre-training competence in empathic responding and assessment of problem situations was outlined. Each subject had been given (in their packet) the telephone numbers of two individuals who would be contacting them by telephone in a role-played Parentline-type call. Subjects were instructed to contact their assigned callers and schedule a time for the calls, which were to be completed prior to the first training meeting. All calls were taped (with subject awareness and consent) by means of electronic devices that enabled tape recorders to record both sides of the conversation. Post-training assessment of empathic responding and assessment skills followed the same general procedure.

Twenty-five hours of training time were divided into ten two and a half hour sessions. The training procedure for the full training groups is outlined in detail in Appendix A (see also Newcomb, Chenkin, Card, & Ialongo, 1984). To summarize, sessions were both didactic (information on child development, parenting, etc. was presented) and experiential (all members were required to participate in role-plays of callers and responders). Training procedure for the partial training group was similar, except that presentation of didactic material during the training seminars was omitted. Identical handouts and written materials were administered, but no

organized lectures were given. Time for answering questions arising from the training materials and role-plays was provided, despite the somewhat didactic quality of the discussions that ensued.

After completing the training, subjects were again administered the Child Development Questionnaire (CDQ), Parenting Skills Questionnaire (PSQ) and the Sensitivity to Children Scale (STC). Role plays were also performed as before.

Measures

Definition of Skills

Four skills were set forth as necessary and sufficient for adequate Parentline performance. These were:

1) empathic responding
2) knowledge of assessment
3) knowlege of child development
4) knowledge of parenting skills

One additional skill of possible relevance to Parentline performance was:

5) sensitivity to children

Evaluative Techniques

Several evaluative techniques were used to assess trainees' performance in the above areas. The paper and pencil questionnaires; the Child Development Questionnaire, the Parenting Skills Questionnaire and the Sensitivity to

Children Scale were used to assess knowledge of child development, knowledge of parenting skills and sensitivity to children respectively.

In order to assess empathy skills and knowledge of assessment, role played calls were used. Four typical Parentline calls were constructed with detailed background information, by four clinical psychology graduate students each of whom had completed a minimum of one year's experience working on the Parentline. These calls were administered to each subject, two prior to and two subsequent to training. The order of administration was rotated to control for order effects. Two of the problem areas used in these calls were practiced by subjects or discussed in detail during training. Each subject received, before and after training, one call in a practiced problem area as well as one in a non-practiced area. Role-play calls were taped and used in two procedures described below.

Role play callers were also graduate students who had completed the Parentline training program and who had a minimum of one year's experience working on the Parentline. Role players were instructed to maintain consistency of affect, openness to questions, and openness to the order and ease with which information was presented to the subjects.

Empathic responding. To assess the first skill area, empathic responding, trained raters assessed taped calls

using Truax and Carkhuff's (1967) rating scale for empathy.

Scoring. Empathy scores were calculated as follow: (1) Raw scores: Scores assigned by raters. (2) Change in raw scores: Post-training raw score minus pre-training raw score

Knowlege of assessment. To assess the second skill area, knowledge of assessment, a separate group of trained coders evaluated the taped calls. These raters checked for the presence or absence of information which was rated for importance to an adequate assessment by experienced Parentline workers. These ratings were on a one to five scale where one meant trivial and five meant crucial. A criterion score was established by having three trained and experienced Parentline staff members do the role plays.The lowest score received was used as the criterion score for Assessment skills.

Scoring. Assessment scores were calculated as follow: (1) Raw scores: Sum of the weighted values assigned to each bit of information gathered. (2) Change in raw scores: Post-training raw score minus pre-training raw score. (3) Criterion level: Lowest score achieved by trained staffers. (4) Percent of criterion: Raw score divided by criterion times 100. (5) Change in criterion level: Post-training percent of criterion minus pre-training percent of criterion

Knowledge of child development. The fourth skill area, knowledge of child development, was assessed by using the Child Development Questionnaire (CDQ). The CDQ was developed by combining tests from seven currently used teachers' handbooks for child development textbooks. This amalgamation was then culled by three qualified persons familiar with the workings of a Parentline service. Two were Ph.D. level psychologists, and had supervised a Parentline type service. The third was an M.A. level clinical psychology graduate student.

Questions that were selected as important by two or more of the three raters were included in the test and duplications were removed. The resultant test was the CDQ which is a 100 point test comprised of multiple choice, true-false, and a short essay question. A criterion score was established by having three trained and experienced Parentline staff members take the test. The lowest score received was used as the criterion score for knowledge of child development.

Scoring. Knowledge of child development scores were calculated as follow: (1) Raw scores: Total number correct answers. (2) Change in raw scores: Post-training raw score minus pre-training raw score. (3) Criterion level: Lowest score achieved by trained staffers. (4) Percent of criterion level: Raw score

divided by criterion times 100. (5) Change in percent of criterion: Post-training percent of criterion minus pre-training percent of criterion.

Knowledge of parenting. To assess the fifth skill area, knowledge of parenting, the Parenting Skills Questionnaire (PSQ) was developed. This was created by the selection of basic parenting principles delineated in Living With Children (Revised) by Patterson (1980). True-false, short answer, and short essay questions that cover these principles were devised. A criterion level was created in a manner identical to that for the CDQ.

Scoring. Knowledge of parenting scores was calculated as follow: (1) Raw scores: Total of correct answers. (2) Change in raw scores: Post-training raw score minus pre-training raw score. (3) Criterion level: Lowest score achieved by trained staffers. (4) Percent of criterion: Raw score divided by criterion level times 100. (5) Change in percent of criterion: Post-training percent of criterion minus pretraining percent of criterion.

Sensitivity to children. This skill area was assessed by means of the Sensitivity to Children measure, which is a collection of parent-child vignettes. Trainees responded to the vignettes by writing exactly what they would say to the child represented in the stories if they were their parents.

Trainees' responses to these interactions were assessed by trained raters. These raters classified subjects' responses according to which of six categories they fell into. The categories were ranked by degree of sensitivity, and responses were weighted according to the ordinal position of the category they represented.

Scoring. Sensitivity to children scores were calculated as follow: (1) Raw scores: Total of weighted values assigned by raters. (2) Change in raw scores: post-training raw score minus pre-training raw score.

Hypotheses

In order to assess the quality of training, the following hypotheses were tested:

H.1: All groups have scores on pre-test measures below criterion levels.

H.2: Full training groups improve significantly on all measures that assess skills specifically trained for.

H.3: Full training groups improve more than partial training groups for those areas in which the partial training group was not specifically trained.

Based upon these research hypotheses the following null hypotheses were formulated for the purposes of statistical analyses:

Ho1: Scores of the subjects in the full training groups show no changes (pre to post training) on measures assessing the skill areas for which they received specific training.

Directional Hypothesis: Full training subjects' post-training scores are greater than their pre-training scores.

Ho2: Partial training group have no changes in their raw scores (pre to post training) or in their percent of criterion scores in the areas for which they received specific training.

Directional Hypothesis: For skills in which they have been trained, subjects' post-training raw scores and percent of criterion scores are greater than their pre-training scores.

Ho3: Full training groups' subjects' scores do not differ from partial training groups' scores in areas for which the partial training group has not been specifically trained.

Directional Hypothesis: In skill areas for which they have not received training, the partial training group has post-training raw scores and percent of criterion scores lower than those of the other groups.

Ho4: There is a difference between criterion levels and post-training scores for subjects receiving specific

training in the relevant areas.

Directional Hypothesis: Subjects' post-training scores are greater than or equal to criterion scores in areas in which they receive specific training.

HO5: There are no differences between criterion scores and subjects' pre-test scores.

Directional Hypothesis: Criterion scores are greater than subjects' pre-training scores.

Statistical Analyses

In order to test hypotheses 1, 2, and 3, five 2 x 3 analyses of variance were performed. There was one 2 x 3 ANOVA (time by group) performed for each instrument. The 2 x 3 analyses were designed to show:

A. Whether there were any changes pre to post for the full training groups in each skill area.

B. Whether there were any changes pre to post for the partial training group in each skill area.

C. Whether there were differences in the amount of change pre to post between the groups that received training and the group that did not receive training in a particular skill.

In order to test hypotheses four and five, confidence intervals were constructed to compare each group's mean

score on each measure with the relevant criterion score. These were done using pre-training scores and post-training scores. These analyses were designed to show:

A. Whether each group began training with scores below criterion levels

B. Whether each group reached criterion after receiving training

In addition to the above hypothesis-testing statistical procedures, Kudor-Richardson reliability analyses were performed to assess the reliability of the Child Development Questionnaire and the Parenting Skills Questionnaire. A test-retest reliability was also performed for the CDQ, and inter-rater reliabilities were calculated for the Empathy, Assessment, and Sensitivity to Children measures.

CHAPTER 3

Results

Several questions related to the training of competent paraprofessionals on a service such as the Parentline were investigated in this study. Four skill areas were identified as necessary for adequate performance. These were possession of knowledge of child development, knowledge of parenting skills, ability to perform adequate assessment of problem situations, and the ability to display empathy. Measures designed to evaluate these were, respectively, the Child Development Questionnaire (CDQ), the Parenting Skills Questionnaire (PSQ), assessment ratings of roleplays (Assessment), and the Truax-Carkhuff Accurate Empathy (1978) scale (Empathy). A fifth subject area of possible relevance was the ability to understand children's needs and react to them in appropriate caring ways. This was assessed by means of the Sensitivity to Children Scale (STC).

Reliability of Measures

Reliabilities for the measures used in this study were computed in several ways. On the Child Development Questionnaire (CDQ) a Kudor-Richardson coefficient was calculated after excluding zero-variance items (see Appendix B for a list of these items). The result was an extremely

low reliability, .08 (Table 2). A test-retest reliability analysis was performed to determine the reliability of the CDQ over time. The results indicated that the CDQ was not reliable over time (.34).

Next, a confirmatory cluster analysis was performed to attempt to increase reliability by dividing questions into four content areas; questions concerning developmental milestones, concerning medical needs, concerning social-emotional factors, and concerning parental demands. These clusters were not reliable (none exceeded an Alpha of .10). A second attempt was made to form reliable clusters using a different structuring, into physical health and development, caretaking, adolescence and sexuality, psychopathology, emotional and cognitive development. Again results were disppointing with only two clusters maintaining an Alpha greater than .10. These were adolescence and sexuality (.50), and physical health and development (.29)

These clusters were altered by deleting items that diminished their reliabilities. This resulted in 4 of the six clusters having Alphas over .30. The final result was four clusters; physical/cognitive development (13 items: Alpha=.45), divorce and single parent issues (4 items: Alpha=.38), psychopathology (5 items: Alpha=.42, and adolescence and sexuality (Alpha=.49, 5 items). (See Appendix B for items falling into these clusters and their

TABLE 2

Reliabilities for Parenting Skills Questionnaire (PSQ), Child Development Questionnaire (CDQ), and CDQ Clusters

Measure	Type of reliability	coefficient
PSQ	Kudor-Richardson across all items	.73
CDQ	Kudor-Richardson across all items	.08
	Test-retest	.34
CDQ Clusters (Kudor-Richardson reliabilities):		
Cluster 1: Physical/cognitive development		.46
Cluster 2: Divorce and single parent issues		.39
Cluster 3: Psychopathology		.42
Cluster 4: Adolescence/sexuality		.43

inter-correlations).

Further attempts were made to form clusters with higher reliabilities and larger numbers of items (such as re-combining items from the four clusters into one cluster or attempting to establish different groupings of clusters). However, even though one large cluster with a marginal reliability of .43 (27 items) was found, it was not reliable over time (the Alpha was .01 on the post-test: See Appendix B for details). Thus it was concluded that the CDQ failed to be a reliable instrument assessing knowledge of child development.

A Kudor-Richardson procedure was used in order to obtain a measure of inter-item reliability on the Parenting Skills Questionnaire (PSQ) resulting in a coefficient of .73 (Table 2). This indicated that the PSQ was a reliable measure.

On the Assessment measure, three tapes in each of the four problem areas (Bedtime, Toilet Training, Sibling Rivalry, Sexuality) were rated by both the primary rater and an alternate. In order to control for practice effects on the raters' analyses, four tapes were initially rated, and eight more tapes were selected throughout the course of the raters' analyses. The inter-rater reliabilities (percent agreement) for the first four tapes ranged from 75% to 88% with an average of 78.75% (Table 3). The reliability for

TABLE 3

Reliabilities for Assessment, Assessment Content Areas, Empathy, and Sensitivity to Children (STC)

Measure	Type of reliability	coefficient
Assessment	Inter-rater percent agreement	.78
Empathy	Inter-rater percent agreement	.75
STC	Inter-rater percent agreement	.71

the other eight tapes averaged 77.8%. Therefore, no practice effects were found. The range of reliabilities for the tapes overall was 69% to 88% with an average of 78%. The range of differences in total points between the raters extended from a low of 6 points to a high of 35 points. The average difference was 22.6 points (on measures where possible points exceeded 200).

Reliability on the Empathy measure was assessed by means of percent of agreement between raters. On the twelve tapes, both raters were in agreement 75% of the time (inter-rater reliability = .75: Table 3). On the tapes in which the raters' scores differed, the difference was never more than one point. A Kudor-Richardson procedure was precluded by the fact that each subject received only a single summary score in each role-play area.

In order to assess inter-rater reliability of the STC, one alternate rater rated ten stories. These results were compared to the scores generated by the primary rater. Agreement was found on 71% of the ratings (Table 3).

With the exception of the CDQ, these reliabilities were considered to be adequate to support the conclusions derived from further analyses.

Results of Analysis of Variance Procedures

In order to make scales more comparable, and to provide clear levels of adequate performance, primary analyses were

performed by calculating criterion scores on all measures (see Table 4 for criterion scores). On the CDQ, PSQ, and Assessment measures, criterion scores were developed by administering the measures to five Parentline workers with at least one year's experience and judged to be operating adequately by their supervisor. The lowest score obtained on each measure was utilized as the criterion denoting minimum score for assured competence. On the Empathy measure, the criterion used was that which was the minimum earned by trained workers, and was identical to that selected by professional colleagues as the minimum necessary score.

As can be seen in Tables 5 and 6 the mean score for each group changed from pre-training to post training in the predicted direction. In order to assess the statistical significance of the changes, three by two (group by time, i.e., pre to post) analyses of variance were performed for each of these areas. These results are portrayed in Table 7.

The group by time ANOVA for the CDQ indicated that there was a significant increase (from $\underline{M}$ = 93.43, [$\underline{SD}$ = 5.37], to $\underline{M}$ = 103.1, [$\underline{SD}$ = 4.27])in percent of criterion scores with training ($\underline{F}(1,2) = 91.54$, $\underline{p} < .0001$). There were no significant differences in the changes among the groups and no interaction effects. Owing, however, to

TABLE 4

Criterion Scores for Child Development Questionnaire (CDQ), Parenting Skills Questionnaire (PSQ), Empathy, and Assessment

Measure	Criterion score
CDQ	72
PSQ	42
Empathy	4
Assessment:	
Bedtime	155
Sexuality	125
Toilet training	140
Sibling rivalry	190

Note. Criterion scores are scores defining minimum adequate performance (Empathy, Assessment) or knowledge (PSQ, CDQ).

TABLE 5

Means (M) and Standard Deviations (SD) by Group in Percent of Criterion Scores for CDQ, PSQ, and Empathy Measures

Group:		Graduate		UGFT (a)		UGPT (b)	
Measure		Pre	Post	Pre	Post	Pre	Post
CDQ	M	93.89	104.86	93.89	102.36	92.50	102.08
	(SD)	(5.07)	(2.63)	(5.71)	(4.58)	(5.32)	(5.60)
PSQ	M	56.43	102.14	56.43	104.76	40.00	90.52
	(SD)	(13.84)	(13.15)	(17.78)	(10.84)	(17.08)	(9.83)
Empathy	M	92.50	113.75	58.75	98.75	66.25	95.00
	(SD)	(42.57)	(31.43)	(24.33)	(18.11)	(30.07)	(25.82)

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

TABLE 6

Means (M) and Standard Deviations (SD) by Group

in Percent of Criterion Scores

for Cumulative and Content Area Assessment

Group:		Graduate		UGFT (a)		UGPT (b)	
Measure Assessment:		Pre	Post	Pre	Post	Pre	Post
Cumulative	M	59.86	119.70	66.89	100.29	69.57	100.41
	(SD)	(12.67)	(8.94)	(8.32)	(8.56)	(19.07)	(11.13)
Content areas:							
Bedtime	M	44.39	122.71	54.59	77.55	32.39	81.29
	(SD)	(18.13)	(18.37)	(15.60)	(13.35)	(22.88)	(28.72)
Sexuality	M	53.60	119.68	68.48	109.28	88.64	112.48
	(SD)	(10.61)	(20.74)	(15.14)	(9.08)	(9.52)	(16.23)
Toilet Training	M	64.71	125.14	75.14	112.86	71.57	104.14
	(SD)	(9.21)	(8.23)	(16.84)	(11.96)	(21.29)	(13.46)
Sibling Rivalry	M	76.74	111.26	69.37	101.47	85.68	104.63
	(SD)	(12.79)	(6.73)	(23.92)	(18.85)	(14.15)	(11.82)

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

TABLE 7

Group by Time (pre to post) Analysis of Variance Summary Table for CDQ, PSQ, Assessment, and Empathy Measures

Measure	Source of variance	Sum of squares	Degrees of freedom	*F* value
CDQ	Group	41.40	2	.62
	Error	905.11	27	
	Time	1390.86	1	91.54***
	T X G (a)	15.80	2	.52
	Error	905.11	27	
PSQ	Group	1349.00	2	2.54
	Error	7182.78	27	
	Time	39795.00	1	310.12***
	T X G	489.00	2	1.91
	Error	3464.78	27	
Assessment	Group	510.22	2	2.08
	Error	3312.29	27	
	Time	25574.00	1	141.67***
	T X G	2572.00	2	7.13**
	Error	4874.18	27	

* $p < .05$
** $p < .01$
*** $p < .001$

TABLE 7 cont.

Measure	Source of variance	Sum of squares	Degrees of freedom	*F* value
Empathy	Group	7359.38	2	2.40
	Error	41390.62	27	
	Time	13500.86	1	58.47 ***
	T X G	890.63	2	1.93
	Error	6234.37	27	

(a) T X G refers to Time (pre to post) by Group

*p < .05
**p < .01
***p < .001

the low reliability of this measure, the results cannot lead to conclusions regarding differences pre to post training and difference among groups.

On the PSQ, a significant difference due to training ($F(1,2) = 310.12$, $p<.0001$) was found and was accounted for by higher post training scores (from $M = 50.95$, [$SD = 16.23$] to $M = 99.14$, [$SD = 11.27$]) and there were no significant differences among groups nor interaction effects. Similar findings were reached on the Empathy ANOVA ($F(1,2) = 25.24$, $p<.0001$: from $M = 72.50$, [$SD = 32.32$] to $M = 102.5$, [$SD = 25.12$]). On the Assessment ANOVA, a significant pre to post change was found ($M = 65.44$, [$SD = 13.35$] to $M = 106.8$, [$SD = 9.54$]): $F(1,2) = 141.67$, $p<.0001$), however an interaction effect was also found. A Student-Neuman-Keuls test was performed comparing changes in the three groups for percent criterion scores pre to post training. Results (Table 8), indicated that the interaction effect was due to a greater mean increase in criterion score pre to post training for the graduate group (from $M = 59.86$. [$SD = 12.67$] to $M = 119.70$, [$SD = 8.94$]) in comparison to the two other groups (UGFT: from $M = 66.89$, [$SD = 8.32$ to $M = 100.29$, [$SD = 8.56$]; UGPT: from $M = 69.57$, [$SD = 19.07$] to $M = 100.41$, [$SD = 11.13$]).

TABLE 8

Student-Neuman-Keuls Test for Assessment

Change in Percent of Criterion Score

Group:	Graduate	UGFT(a)	UGPT(b)
M	59.83	*33.30	31.14

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

Note. Ranges for .05 level of significance = 2.90, 3.50

*$p < .05$

Confidence Interval Analysis

To test the hypotheses that all groups had pre-test scores below criterion levels, and post-test scores equal to or above criterion levels, 95% confidence intervals were constructed around the groups' raw score means. These intervals extend a range of possible mean scores that has a probability of .95 of including the actual true mean. If the criterion score falls above this interval, we can be confident in assuming that it is larger than the group mean.

If the criterion level falls below the confidence interval, we can conclude that the group mean equalled or surpassed criterion. If it falls within, we cannot make either claim with the same degree of certainty. The formula for constructing these intervals is:

$M \pm 2.62(SD)$ with 9 degrees of freedom (Hays, 1973)

In the following tables, pre- and post-test confidence intervals are reported for each test.

In Table 9, we see that for the CDQ, mean group scores prior to training differed significantly from our measure of significance only in the Undergraduate Partial Training Group. It is true however, and of clinical importance, that only one group member in each group entered the training with a score on the CDQ equal to or greater than criterion.

TABLE 9

CDQ and PSQ Confidence Intervals in Percent of Criterion Scores

CDQ

Criterion = 72

Pre-test:			
Group:	Graduate	UGFT(a)	UGPT(b)
M	93.89	93.89	92.50
Confidence interval	89.69 - 98.09	89.16 - 98.62	88.09 - 96.91
Post-test:			
Group:	Graduate	UGFT	UGPT
M	104.86	102.36	102.08
Confidence interval	102.68 - 107.04	98.56 - 106.16	97.44 - 106.72

PSQ

Criterion = 42

Pre-test:			
Group:	Graduate	UGFT(a)	UGPT(b)
M	56.43	56.43	40.00
Confidence interval	44.96 - 67.90	41.69 - 71.17	25.84 - 54.16

TABLE 9 cont.

Group:	Graduate	UGFT(a)	UGPT(b)
M	102.14	104.76	90.52
Confidence interval	91.24 - 113.04	95.76 - 113.76	82.37 - 98.67

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

We further see that on the post-test scores, while each group has a mean exceeding the criterion score, the criterion score falls within the confidence interval for each undergraduate group, but is excluded in the predicted direction for the graduate students. It is of clinical significance to note that all ten members of the Graduate group exceeded the criterion score as did nine of the Undergraduate Full Training (UGFT) group and 7 of the Undergraduate Partial Training (UGPT) group. This suggests that most students acquired an understanding of child development during the training, and that the type of training program did not make much difference in this acquisition. However, as stated previously, the reliability problems with the current measure of child development render any such conclusions extremely tentative.

Table 9 also illustrates how, on the PSQ, confidence intervals for scores of each group fall below the criterion score prior to training. This suggests the descriptive fact that no member of any group equalled or surpassed their criterion score on the PSQ prior to training.

Post training scores show that group means equalled or surpassed criterion scores except for the UGPT group which failed by 9.48 percentage points. Again, the confidence intervals included the criterion score, this time by a more comfortable margin. On this measure, six Graduate group

members exceeded criterion scores, eight UGFT members, and six UGPT members also did so. Again, results suggest that parenting skills increased in all three groups regardless of the type of training program.

In Table 10 are reported the confidence intervals constructed around group mean raw scores for each of the four Assessment scale problem areas, both pre- and post-training. Scrutiny reveals that for the pre-test scores, criterion scores were excluded from the confidence intervals in the predicted direction in all four problem areas for all four groups. It is again of clinical importance to note that all members of this group failed to reach criterion in every area.

On the post-test scores, the Graduate group had confidence intervals that exclude the criterion score in the predicted direction in all four problem areas. All 20 post-test scores in the group exceeded criterion.

For the UGFT and UGPT groups, three of four problem area means exceeded criterion scores. In the Full Training group, two of four problem areas' confidence intervals excluded the criterion, while none of the Partial Training groups' did. For the UGFT group, 12 of 20 scores exceeded criterion while for the UGPT group, 14 of 20 exceeded or equalled criterion.

Table 11 displays the confidence intervals constructed

TABLE 10

Assessment Content Area Confidence Intervals

in Percent of Criterion Scores

Bedtime

Pre-test:			
Group:	Graduate	UGFT(a)	UGPT(b)
M	44.39	54.59	32.39
Confidence interval	29.36 - 59.42	41.66 - 67.52	13.39 - 51.39
Post-test:			
Group:	Graduate	UGFT	UGPT
M	122.71	77.55	81.29
Confidence interval	107.48 - 137.94	66.49 - 88.61	57.48 - 105.10

Sexuality

Pre-test:			
Group:	Graduate	UGFT(a)	UGPT(b)
M	53.60	68.48	88.64
Confidence interval	44.80 - 62.40	55.93 - 81.03	80.74 - 96.54

TABLE 10 Cont.

Post-test:

Group:	Graduate	UGFT	UGPT
M	119.68	109.28	112.48
Confidence interval	102.49 - 136.87	101.75 - 116.81	99.02 - 125.94

Toilet Training

Pre-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	64.71	75.14	71.14
Confidence interval	57.07 - 72.35	61.17 - 89.11	53.92 - 89.22

Post-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	125.14	112.86	104.14
Confidence interval	118.32 - 131.96	102.94 - 122.78	92.98 - 115.30

TABLE 10 Cont.

Sibling Rivalry

Pre-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	76.74	69.37	85.68
Confidence interval	66.14 - 87.34	49.54 - 89.20	73.95 - 97.41

Post-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	111.26	101.47	104.63
Confidence interval	105.68 - 116.84	85.84 - 117.10	94.83 - 114.43

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

TABLE 11

Assessment Confidence Intervals in Percent of Criterion Scores

Cumulative over Content Area

Pre-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	59.86	66.89	69.57
Confidence interval	49.36 - 70.36	59.99 - 73.79	53.76 - 85.38

Post-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	119.70	100.29	100.41
Confidence interval	112.29 - 127.11	93.19 - 107.39	91.18 - 109.64

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

around group mean percent of criterion scores collapsed over the four problem areas. On the pretest scores, all three confidence intervals exclude the criterion (100%) in the predicted direction. The Graduate group's confidence interval excluded the criterion, while both of the other groups' confidence intervals included the criterion point. These results suggest that the Graduate group succeeded in gaining adequate assessment skills during the training, while the Undergraduate groups' results were more variable.

On the Empathy measure (Table 12), no group's confidence interval excluded the criterion score (100% of criterion) except both undergraduate groups' pre-test, which excluded it in the predicted direction. Of clinical importance, four group members had pre-training Empathy scores equal to or exceeding criterion, for a total of 6 out of 20 possible occasions. In the UGFT group, 3 members equalled or exceeded criterion 4 out of 20 possible times. The UGPT group had 2 members reach criterion on a total of two occasions. On the post-test measure, none of the groups' confidence intervals excluded criterion, with only the Graduate mean exceeding criterion. On individual scores, however, within the graduate group, 17 out of 20 scores equalled or exceeded criterion with eight members always at or above criterion. In the UGFT group, 13 scores are at or above criterion with 5 members always equal or above. The

TABLE 12

Empathy Confidence Intervals in Percent of Criterion Scores

Pre-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	92.50	58.75	66.25
Confidence Interval	57.21 - 127.79	38.58 - 78.92	41.32 - 91.18

Post-test:

Group:	Graduate	UGFT(a)	UGPT(b)
M	113.75	98.75	95.00
Confidence interval	87.69 - 139.81	83.74 - 113.76	73.60 - 116.40

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

UGPT group had 11 scores at or above, with 4 members reaching criterion on both post-test occasions. To summarize, the results of the Empathy measure indicate that 80% of the Graduate group reached or exceeded criterion post training, while no more than 50% of the other two groups did so.

Sensitivity to Children Measure

The fifth skill area, whose results have not yet been discussed was that measured by the STC. There are no criterion scores for this measure because it is not clear there is a criterion for successful performance. The relevance of this skill to Parentline work is unclear. Change was measured by ranking each category on a healthful-destructiveness axis. Each response was weighted according to its category and the responses were averaged. Improvement would entail change toward use of the healthier categories. The categories and their rankings follow:

(1) Ridiculing/interrogating
(2) Authoritarian control/psychological dominance
(3) Instrumental control
(4) Instructing/lecturing
(5) Adult expression of child's influence
(6) Empathy

Thus, improvement would be evidenced by larger mean scores on the post-training measure than are found on the pre-training measure.

Table 13 presents STC means for weighted response scores, where response categories range from (1) Ridiculing to (6) Empathy. As can be seen, there was a significant change in scores on the STC in the predicted direction. Thus, it appears clear that efficacy on the STC is a skill that improves with the training program offered. The smallest change was in the Graduate group which changed .59. One of the most consistent changes was in the increase of empathy responses. This is not surprising as it is the one area in which training could directly influence scores. There is nevertheless an extremely large change in each group in decreasing Authoritarian Control responses. This was not a part of training, and it is felt that this does demonstrate the effectiveness of the training in altering trainees' sensitivity to the needs of children.

TABLE 13

Sensitivity to Children (STC) Measure: Descriptive Statistics for Response Categories in Number of Responses per Group

Group:	Graduate		UGPT(a)		UGFT(b)	
	Pre	Post	Pre	Post	Pre	Post
Category and rank (c)						
(1) Ridiculing	2	3	16	4	9	3
(2)Authoritarian control	38	18	44	7	31	10
(3)Instrumental control	12	14	11	10	16	18
(4)Instructing/ lecturing	12	9	19	3	20	8
(5)Adult exp. of childs Infl.	5	4	14	10	13	9
(6)Empathy	43	57	25	33	31	38

Summary of mean STC scores across groups pre to post

Group:	Graduate		UGPT(a)		UGFT(b)	
	Pre	Post	Pre	Post	Pre	Post
	3.97	4.56	3.35	4.59	3.75	4.44

(a) UGFT refers to the undergraduate full-training group

(b) UGPT refers to the undergraduate partial-training group

(c) Items are ranked from low to high on the extent to which they reflect sensitivity to children.

CHAPTER 4

Discussion

There were several important questions asked in this study:

1. What are the important skill areas critical to competent service in a Parentline type of program?
2. How can these skill areas be evaluated?
3. Can paraprofessionals be trained with these training packages to deliver adequate service?
4. Does training variety affect paraprofessional performance?
5. Do graduate students perform at a higher level of competence than do undergraduates?

Experimental Hypotheses

The experimental hypotheses designed to evaluate these questions were:

1. All groups have scores on pre-test measures below criterion levels.
2. Full training groups improve significantly on all measures that assess skills specifically trained for.
3. Full training groups improve more than partial training groups for those areas in which partial training groups are not specifically trained.

Importance of Skill Assessment in Paraprofessional Training

All too often, delineation of skill areas necessary in a paraprofessionally and professionally staffed mental health program, is not done at all (France, 1975). As a result, it becomes difficult to assess the state of preparedness of staff members to provide service. This can lead to an inability to rely on anything other than clinical judgements in deciding upon the inclusion or exclusion of prospective workers. It also becomes more difficult to provide training, since no decision has been reached about what areas in which to train workers. Finally, it becomes difficult to compare programs when one considers the general effectiveness of paraprofessionals in a variety of services. Considering the gap between the number of professional service providers and the need for services, the need for verifiably, measureably adequate service by paraprofessionals becomes clear.

Skill Assessment and Reliabilities in the Current Study

Four skill areas were selected by the investigator as critical for Parentline staff members. These were agreed upon in discussion with other experienced administrators and staff members of the Parentline. The first four areas are knowledge of child development, knowledge of parenting strategies, assessment skills, and empathic responding. In addition, a fifth area of possible importance was suggested,

that of sensitivity to children, as measured by the Sensitivity to Children Measure.

The second need was to find measures that can evaluate trainees in these skill areas. In selecting these measures, it was important to insure that the utilization of them was reliable. Without this, while scores are obtainable in each skill area, no statements can be made with any confidence that they are accurate reflections of the trainees' capabilities, and thus to use them in choosing staff members would be insupportable.

The CDQ measure was shown to have insufficient reliability to sustain conclusions based upon its usage. This remained so despite attempts to create internal divisions with adequate reliability through performing confirmatory cluster analyses. There are several possible reasons for the low reliability on the measure of child development. One is that there were too many questions that almost all or none of the subjects answered correctly, thus diminishing the test's capacity to distinguish among subjects of different skill levels. Another is that despite the use of consensual validation in constructing the measure, it is possible that the relevant areas of child development were not appropriately covered, therefore again failing to distinguish properly among subjects. Accordingly, it is recommended that in constructing a

substitute measure, these sub-areas be identified and questions chosen in such a way as to adequately test subjects' expertise in each of them. Examples of these sub-areas would be knowledge of developmental milestones, knowledge of norms for different types of interpersonal interactions such as peer relations or sexuality, knowledge of stages of cognitive development, and physical/medical needs.

The need for verifiable and reliable measurement of skill areas was met for parenting (PSQ), assessment, empathy (Carkhuff-Truax,1967) and sensitivity to children (STC). These measures can be used in evaluating the performance of staffers on a Parentline type of service. There is still a need, however, for a measure that can assess knowledge of child development.

Adequacy of Paraprofessional Services on Parentline

The next question involves whether paraprofessionals can be trained to provide Parentline services. In its broadest sense, this was a given since the levels used as criteria for adequate performance were gained by using scores of staff members who were themselves graduate student paraprofessionals with a minimum of one year's experience each. Thus, the assumption was made that after a year of answering the phone and being supervised both live and in weekly group sessions, paraprofessionals could be certified

as competent by supervisors familiar with their work. Questions that remained to be answered, however, included whether paraprofessionals can be expected to do an adequate job from the beginning of their service.

Of the ten graduate students and their sixty post-training scores, there were fifty three scores at or above criterion. Prior to testing, there were six scores at or above criterion, all on the Empathy measure. Six of the ten graduate students reached criterion on all measures and would thus have been considered adequately trained to function on the Parentline. Among the remaining four graduate students, one failed to reach criterion on three measures (both content areas of the Empathy measure and on the PSQ), one failed to reach criterion on one Empathy content area measure (by one point), and two missed on the PSQ alone (7 points each). This group achieved a sixty percent pass rate.

For the Undergraduate Full Training group, forty two of sixty possible post-test scores reached or exceeded criterion. One student passed on all measures, five missed on only one measure (three on one of the Assessment content area measures, and one each on the PSQ or one Empathy content area measure). The remaining students failed criterion on three or four measures. Only one student was immediately ready to provide Parentline service,

but another five would probably have been ready after receiving limited further specialized work.

In the Undergraduate Partial Training group, thirty eight of the possible sixty scores reached or exceeded criterion. Again, one student reached criterion on all measures, and four students failed on one measure (divided among the four skill areas). The remaining students missed on three to five scores.

From these results, it can be adduced that it is possible to train paraprofessionals to work on the Parentline. Twenty seven percent of all subjects passed on all scores. Another thirty percent failed on only one score and thus could arguably have profited by a minimal amount of further remedial work before being adequately prepared. This indicates that the Parentline is a program which can be expected to successfully draw upon the pool of paraprofessionals available for service.

Population Pool for Paraprofessional Training

A further question, however, is that of which types of paraprofessionals can be trained with this program to provide adequate service. Another factor in the use of paraprofessionals is that the types of person used in services often are not comparable, thus making comparison across programs difficult. The needs of training one group may not be exactly the same as that for another group.

Therefore it is important to examine the differences between the graduates and undergraduates trained. Numerically, the differences appears clear - six of ten graduate students were fully trained and three just missed. Of the twenty undergraduate students, two were fully trained and nine just missed by one score. The only statistically significant differences found were between the graduate and undergraduate groups.

Measuring change solely in terms of success in reaching criterion risks making misleading conclusions more likely. This is because a group could change from none to ten subjects reaching criterion without demonstrating that statistically significant change can be established. While the small group N's and large standard deviations disturb the clarity of the answer to whether group means differed significantly from criterion in the appropriate directions pre and post, the overall picture retains sharpness. All groups had statistically significant change pre to post in the primary skill areas. The graduate group's results demonstrate that the training program is adequate, particularly if provisions were to be made for remedial work for subjects who fail to pass on one score. Undergraduate groups need more training to reach an adequate level of performance.

Effects of Different Types of Training

Another question concerned the hypotheses that there would be differences among the undergraduate groups in areas of differential amounts and types of training (the partial training group was hypothesized to be higher on experiential measures - Empathy and Assessment; the full training group was hypothesized to be higher on didactic measures - CDQ and PSQ). No statistical support was found for these hypotheses.

Several factors are thought to have contributed to these lack of differences. One is that using an academic course designed for undergraduate credit created a necessity to impart a certain amount of information to both groups. This may have blurred the distinctions between the groups by increasing the amount of didactic instruction in the group that was supposed to receive primarily experiential training. Adding to this was the overlap among the trainers across groups. This too may have served to increase the didactic material by using information presented in one group to answer questions raised in the partial training group. As didactic instruction increased, time for roleplays would decrease and the distinctions between the two groups became lessened.

Another possible explanation is more positive in its ramifications for the training manual. The roleplays were

designed to increase the group member's awareness of what they needed to know in order to function adequately. It is possible that this succeeded in increasing the questions and demand for specific information which would again serve to mitigate the differences between groups. It would be useful to utilize different trainers and a more explicitly experimental situation in order to parse out the contributions of the above possible factors contributing to the lack of significant effect for the type of training administered.

Strengths and Weaknesses of the Study

There are a number of strengths inherent in this study. The first is that an attempt was made to respond to the need (France, 1975) to delineate the critical skills necessary for adequate Parentline staff performance. The second is that generally successful attempts were made to devise instruments capable of reliably measuring subjects' skill levels in the relevant areas. With the exception of knowledge of child development, all measures demonstrated adequate reliability. A third strength lies in the varied forms of evaluation and analog role play situations used. This was a step toward assessing not only knowledge levels but also the subjects' ability to put their knowledge into practice.

Another strength lies in the creation of standardized

role play situations that can be used in replications. Similarly, the standardized psychoeducational program with its handouts (Appendix A) allows both for replications of studies evaluating this training, as well as provision for almost identical training in other settings. The publication of standard evaluative procedures can make the training procedures available for use in evaluating the performance of paraprofessionals working on a variety of programs that utilize one or more of the skill areas. Finally, the use of both graduate and undergraduate students allows for conclusions to be drawn about the pool of prospective trainees for a Parentline service.

Several weaknesses are also evident in the present study. An overarching problem is that of the small number of subjects. This weakened possible conclusions and limited the clarity of the implications of the various analyses. The use of unmatched samples made for possible interference with the demonstration of difference among groups. In this regard, the increased level of experience and age among the graduate group, and the difference in age and experience in the two undergraduate groups, makes conclusions about the increase success of the graduate group less certain (though their scores on most measures were not higher on the pre-training administration).

Another problem was the use of a classroom situation

with its attendant pedagogical responsibilities which possibly vitiated the purity of distinction drawn between training modalities. In addition, the failure of the CDQ to demonstrate adequate reliability leaves a hole in our ability to claim effective training in one of the important skill areas.

Finally, by its very nature, the measures utilized in the study evaluate skill areas and not effectiveness in terms of adequacy of service provision. Ideas for further investigations which would remedy this problem will be considered in the next section.

Suggestions for Further Research

Suggestions for further research fall into several categories. The first involves improvement in experimental design. A larger number of subjects would be the prinicipal change recommended in any replication or follow-up study. Use of a purely experimental situation which included strict controls over training modalities could be fostered by utilizing different trainers for each group, thus minimizing the possibility of carry over from group to group. Matching groups by age, sex, and level of experience (with children) would improve still further the strength of conclusions drawn from the studies.

A second category of suggestions comprise extensions in the populations tested. The use of large pools of

underutilized populations ought to be considered for training programs. Research to consider the advisability of such recruitment could involve groups of neighborhood parents, or retired geriatric populations in their studies.

A third area involves a separate form of evaluations entirely. This concerns the assessment not of theoretically relevant skill areas, but of actual efficacy of service provision. Efforts are presently underway to investigate such efficacy through the development of a questionnaire to use in follow-up calls to Parentline users. This measure can evaluate the service effectiveness, however, no provision has been made to correlate consumer satisfaction with the performance of particular staff members. Hence it is not possible to correlate scores on the measures in this study with data from adequacy of service provision studies. Studies examining this relationship would provide a needed and clear demonstration of the adequacy of the training utilized here.

Summary and Conclusions

In summary, the results of this study indicate that with the exception of the area of child development knowledge, the evaluative materials used in the Parentline training provided an adequate and useful set of measures for assessing the performance of workers on a Parentline type of service. The findings also suggest that graduate students

can be trained by this program to reach a level of performance similar to experienced Parentline staff members. Undergraduates can also be trained, but the success rate will be lower. Creating a remedial program for trainees who have slightly deficient scores post-training may increase the success rate for a variety of populations.

Older paraprofessionals, for example neighborhood volunteers, may be a useful source of competent workers, and the suggestion is further made that studies be done using this non-academic population. The potential for a program like Parentline to further the cause of preventive mental health as proposed by Caplan (1964) has only begun to be explored.

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APPENDIX A

Child Development Manual

CHAPTER 1

NEONATE (0-6 MOS.)

General Comments:

The first basic task of the newborn infant is to make the adjustment to living outside of the womb. The nature of life certainly changes considerably in this alteration. The world becomes brighter, noisier, less consistent. It also becomes arguably more exciting. Infants are called upon to adjust in several areas. Among these are physiological, motoric, emotional and cognitive skills. Of course it is not always possible to separate these categories neatly as there is much overlap.

An obvious but important factor in the life of the neonate is her all but complete dependence on caregivers for the maintenance of her life itself. For parents, paradoxically, this period is characterized both by new and tremendous responsibilities, and by a more restricted range of challenges and problems than will be developing over time. The demands of the infant evoke fewer moral and ethical judgments and pressures than do those of the older child or adolescent. Furthermore the range of an infant's behaviors is much narrower than even a toddler's and thus the parental responses called for are less complicated.

Nevertheless, the very helplessness and seeming fragility of the infant combined with her inability to communicate other than by crying, screaming, cooing and the like, which lack clarity while being undeniably cogent, certainly can make this period of parenthood exceedingly anxiety provoking. The period before the infant sleeps through the night can be particularly exhausting and upsetting. Further, the rapid changes in the infant, e.g. her physical growth and her cognitive development, can be confusing.

Cognitive

Initially the infant's cognitive behaviors are merely reflexive. That is, there is no conscious thought or symbol mediated decision about how to achieve a goal or reflective consideration of what is caused by or happening to the child. The infant has no awareness of cause-and-effect relationships and is in a thoroughly undifferentiated state. By this it is meant that she is not aware that other people and objects are separate from her. As a result she has, e.g. no sense of object permanence. The neonate doesn't know that objects that she ceases to perceive, continue to exist. For example if a block with which a baby has been playing is put out of her view, she will not go searching or reaching for it - it will have ceased to be.

Accordingly, in the earliest stage of cognitive development (corresponding to the first substage of Piaget's

sensory-motor stage) which lasts for approximately the first month of life, the child's behaviors are reflexive. The infant practices these reflexes (without conscious determination to do so, of course) with great diligence. Objects are, in a relatively routine and indiscriminate fashion, assimilated into what Piaget calls a scheme, which is a typical mode of interacting with the environment. For example one of the infant's reflexes is to suck when the nipple is placed within her lips. At this stage of reflexive behavior the infant will suck when any object is placed within her lips - using any object whether appropriate, in a typical manner of interaction with her environment.

As substage two is entered, the infant continues to "practice" her behavioral schemes. These are now gradually developing and changing. She will, for example, suck differently on a nipple than on her toes. It is also in this second substage that schemes begin to be combined into somewhat more complex behavioral patterns. One of the infant's reflexes is that of grasping objects placed in her palm (such as making a tight fist around someone's finger which has touched the inside of her hand. In this substage (which lasts until approximately the fourth month), the infant uses more than one scheme - hence e.g. she will bring objects which she has grasped to her mouth and then suck.

Again this is in a rather indiscriminate fashion. Whatever is in the hand goes to the mouth.

The infant is also developing another capability. She is attaining hand-eye coordination and begins to reach for items to grasp which are in her visual field.

As the infant moves into the third substage, one which lasts approximately four months (until about the eighth month), she is quickly developing greater complexity. This period is a transitional phase between the purely reflexive behaviors of the neonate and the goal oriented conscious behaviors of the older child. The infant previously repeated behaviors reflexively, automatically, paying scarce attention to the characteristics of the objects with which she comes into contact (e.g. when hungry, she'll notice that a toy isn't a breast or a bottle, but will suck whenever it is put to her lips). Before the objects seemed to exist merely to be grasped, sucked, etc. Now however, the objects themselves begin to have some interest for the child - she'll begin to consider them and distinguish among them.

Another characteristic of this third substage is that the infant will frequently find herself performing behaviors that incidentally have effects that delight her. A couple of examples would be rattling a rattle with some sudden movement of her arm, or striking a bell while waving a stick about wildly. Now these actions are likely to be repeated

over and over again. As noted before, this is somewhat of a transitional period, howwever. Previously the behaviors were merely reflexive. Later they will be done in order to cause a pleasant reaction. It is thought though that as yet the infant hasn't developed understanding of cause-and-effect. She hasn't yet understood quite that she is, e.g., acting upon a rattle in such a fashion as to cause the pleasurable noise.

Our young infant then has moved from purely reflexive behaviors carried out in relative isolation from one another, to more complex combinations of behaviors. Goal-directed, intentional conscious behaviors do not yet exist though she will anticipate now (for example, begin to suck upon seeing her caregiver's nipple or the bottle). The infant is still unsymbolic and nonreflective.

Two more behaviors of prime interest to parents ought perhaps to be covered in this cognitive area. One is sleeping and the other is smiling.

Getting parents up through the night is not ordinarily one of the behaviors that most endear the small creatures to caregivers. This perhaps is the cause for the ambivalence demonstrated in the genre of the hostile baby rocking song such as Rock-a-bye-baby. By the time the baby is three months old she may well be sleeping through the night, or most of it. This regularity ought to increase thereafter

with age even while the actual number of hours spent sleeping decrease. The newborn baby will sleep almost all the time during which she is not actually being attended to, over 2/3 of the time. This decreases steadily.

Smiling is a behavior caregivers find important. It can be a reward for their efforts to see a satisfied smile. The smile means different things as the infant develops. During the first month, smiling is usually not present. Thereafter, for about four or five months, the infant will smile at nearly any face or picture of a human face. It is not until later that the infant becomes discriminating and may cease to smile when strangers come near, saving them for her caregivers.

Parenting Demands

The needs of the neonate that parents should fulfill are tripartite. They involve physical well-being, emotional well-being, and intellectual stimulation. Naturally, the parents must neet the child's needs for nutrients, to be kept clean and healthy, etc. Of equal importance to the child's happiness and sound development is tthe parent's attention to the infant's emotional needs.

The primary psychosocial task of the neonate as formulated by Eric Erickson is that of developing basic trust about the world's intentions. After all, the infant is in a state of relative helplessness in a world which can

be perceived as positive, safe, pleasure engendering, or contrarily as dangerous and malevolent. It is through prompt and consistent attending to the infant's needs that this more positive and trustful attitude can be fostered. Infants cannot yet delay gratification. They cannot symbolically represent the parent in memory (cf. object permanence) and thus cannot yet reassure themselves that relief will be forthcoming if they wait awhile.

Besides attention induced by cries and screams, babies thrive with a goodly amount of caressing, holding, nuzzling, fondling, stroking, petting, touching, hugging, tickling, etc. (it is not so bad for the parents either). Short of overstimulation or hurting the child (the baby will not fail to notify the parent of such an event by her cries) these are important needs of the infant.

The neonate is gradually developing attachments. For the first six months or so, the child will not typically protest when people leave her visual field. Through the first 3 or 4 months she may tend to respond indiscriminately to all smiling faces. Towards the end of the 6 month period the infant begins to develop a special attachment to her primary caregiver. This will be discussed further in the next section.

For fostering of the infant's intellectual development, to stimulate her to practice her behavioral "schemes",

interesting objects should be placed first where she can stare at them, and then where she can grasp for and reach them. Objects that will fascinate and stimulate the infant can be brightly colored, slowly moving, variously textured, and different sounding (while not small enough to be swallowed, toxic when sucked on, or sharp enough to injure her).

Motor

A time-line of typical milestones follows. It must be cautioned that this is merely a collection of averages and rough expectations. Normally developing children can and do differ on both sides of the dates given.

2 months: holds head erect

3 months: steps when held erect
turns from side to back
reaches for objects (but misses them)
sits with support

4 months: grasps objects without using thumbs

5 months: rolls from back to side

6 months: pulls to sitting position
sits alone (using hands for support)
reaches with one hand
shifts objects from one hand to the other

Transitions

Generally, this time is one that calls for reactivity on the part of the parents to the infant's communications. Arranging for a flexible, but noticeable routine for sleeping, in particular, will aid in helping the youngster to move toward sleeping through the night.

This time is a tremendous time of transition for the parents. It marks the change from individual or couple to being parents and a family. If there is a single parent, there is a great need to develop social resources so as to avoid exhaustion, frustration, and isolation that can result from attempting to singlehandedly meet the infant's demands.

If the child is born to a living together couple, the transition is no less significant. It is not easy for a couple, often still in the throes of defining their own relationship, to move fluidly to changing the rules of their interactions while at the same time adding on a great number of additional demands. New parents will often find themselves bringing their own parents' styles of child rearing to their new family and find to their consternation that their partner has a different notion of caregiving. The antidote to the problem this transition can engender is communication. Talking to each other and being willing to

compromise will pay dividends over the years.

CHAPTER 2

SIX TO TWELVE MONTHS

General Comments:

This is quite a busy time for the infant and her parents. At the beginning of this phase the child is not symbolic and lacks locomotion. The one year old child has learned to crawl (usually) and then walk, with or without support. She says a few words. She can respond appropriately to a few commands. She can manipulate small objects much more easily than before.

The six month old is not clear about how she is separated from other people and objects in her environment. She doesn't realize that objects that she can't see don't just wink out of existence. She has little understanding of cause-and-effect relationships. She is only beginning to fully recognize her caregivers. By the end of her first year she has gleaned a rudimentary understanding of cause-and-effect. Recognition of and attachment to her caregivers has clearly developed. She has much more differentiation from the rest of the universe.

The one year old child is more playful, she experiments more. She imitates a good deal. She acts more purposively, in a goal oriented manner.

For parents this is both a highly rewarding and an increasingly anxiety provoking time. As the child develops social awareness, this is frequently a time of much play, laughter and smiling. However, as the child's mobility increases and her differentiation improves and its concomitant, the genesis of exploration and autonomy begins to be manifested, many parents become more concerned over how to watch and protect the child, how to maintain sufficient control, and how their caregiving and limit setting affect the child.

Cognitive

There are four particular developmental areas of special note in this six-month period. These involve imitation, object permanence, increased understanding of cause-and-effect, and language.

As is true of all human development these new capabilities are based upon previously mastered skills. These new capacities will in turn aid in the development of new skills.

Younger infants are thought to have at best an extremely murky notion about how their behaviors affect the world. It is true that they can be found gaily repeating an action that has pleasant consequences for them. An example would be an infant reiteratively shaking a rattle, elated by its noise. It is not believed, however, that she

as yet has a sense that it is her act of waving her arm, moving the rattle, that is causing it to make its sound. The causal links develop over time, but they are still tenuous. Our older infant is now beginning to have a clearer understanding that her actions have predictable results. She starts to manifest goal oriented behaviors, for example grasping a rattle and shaking it in order to hear its noise.

Previously our infant had only the bare rudiments of a sense that objects are permanent - that they exist even when she is not observing
them. Now her understanding has sufficiently progressed that when an object is hidden in front of her she doesn't now assume it to no longer exist. Now she will look for it, e.g. removing the cover which someone has placed over it. She does as yet have a curious flaw in her concept however. Frequently she will look for a desired object not where she has just seen someone hide it, but rather where she had last found it. For example, if a small toy is hidden on the left of an infant in this stage, she will find it. Repeat this and once again she will locate the toy. Now, in full view of the child, move the toy to her right side and hide it, and despite her having seen you cover it, she will tend to look again on the left, where she had previously been successful in discovering it.

Another catch in her concept of the permanence of objects is the following. If, for example, a toy animal is hidden in front of her, but a toy car is stealthily substituted for it, the child will upon searching find the car. Though she may be puzzled, she will not search further for the animal - even if it is the preferred toy.

A most important development occurs in this period in the infant's expanded ability to use imitation. While younger infants also imitate, they can only do so for those behaviors that already exist in their repertoire. For example she may cry upon hearing another baby cry. Our older infant in this stage is able to imitate new behaviors. This allows her to begin learning through imitation and she will do so with a vengeance. This is a development which affects the growth of language and it helps set the goals and expectations of the child, for to a large extent what they see and experience is what they will strive toward, and the mechanism is imitation. As yet this capacity is still largely undeveloped but particularly in the area of language learning, it has begun to become significant.

Language development begins early, with the cooing, gurgling and babbling noises the infant produces, in a sense practicing the articulatory skills that will be used later to utter intelligible words. The infant develops receptive speech prior to expressive speech. At the beginning of this

period, the infant probably doesn't understand any words. Within a few months, by the ninth or tenth month of age, she probably can understand a handful of words while she is likely not to produce words herself until the end of the first year, and then only a couple of words or so. However, by this time the infant is likely to understand a number of words and to respond to simple commands (e.g., wave bye-bye).

Social-Emotional

In some ways, the basic emotional task of the 6-12 month old infant is to begin the long complicated process of attaching to others and individuating from others. When younger, as we have seen, the infant did not distinguish between herself and objects (human and otherwise) in her environment. Now she begins to see in fact that she is separate. It is only through this realization that attachment can occur.

This can be an upsetting period for the infant. The more she has learned to perceive her environment as secure, through consistent and prompt attention being paid to her needs, the more able she will be to remain attached while still performing the necessary tasks of the infant that lead in some ways toward individuation and autonomy. A prime example of this is the tremendous curiosity and explorative behaviors of infants of this age. It is usual for infants

to portray the dual tasks of the age quite graphically as they touch their caregivers, crawl away to explore, look back for eye contact, crawl further, return for contact, and wander afield again.

There are two stages that most children pass through regardless of their balance between autonomous and attached behaviors. As the child perceives herself to be separate from her primary caregiver(s) as she begins to attach and become oriented more towards them, recognizing them, searching them out, she typically will begin around the seventh month or so, to cry whenever the caregiver to whom she has made a special attachment leaves her visual field. This is sometimes called separation anxiety.

Contemporaneously or soon afterwards, the baby typically might begin to exhibit signs of distress when people other than her primary caregiver(s) come near. This can extend to people with whom she had previously spent much time. This is sometimes misleadingly called stranger anxiety. While such anxiety generally fades within a few months, these stages usher in a period in which the child is typically less gregarious than before, attaches herself to her primary caregivers quite firmly, and is less tolerant of intrusion or separation from them than before. This is particularly noticeable in contrast to the period before (up to 7 or 8 months or so, generally) in which the child is

extremely sociable.

Demands upon Parents

There are new stresses in the parents' lives in this period, primarily caused by the child's increased skills of locomotion and fine motor coordination. The infant is now to be found up the stairs, under the sink, and underfoot. They're tasting soap, the dog's bones, and cabinet knobs with the avidity of a gourmand while lacking (at least to the jaded adult palate) the fine discrimination of the connoisseur. The attempts of caregivers to make the baby's environment safe (baby-proofing the residence) demand ingenuity and thoroughness.

While it is (obviously) imperative for caregivers to prevent the child's curiosity and ignorance of perils from leading her into danger, it is also important that the infant's adventurous attempts to satisfy her curiosity, to practice and master her locomotive skills, not be constrained. In fact, this is an ideal time to begin or to continue to stimulate the child with toys to stretch her mind or her physical capacities. Items to pick up, thus practicing the pincer grasp, that are not small enough to be swallowed, are a good example of the type of stimulation important at this stage.

While typically children do not not yet have expressive language (other than, e.g. mama and dada), they

can understand words and it is increasingly important that parents speak a great deal to their children. An example is to describe activities that are under way ("now daddy is washing your toes.").

This may be a time to note, also, that girls typically develop faster than do boys, both physically and mentally. Do not be surprised if a younger brother is consistently a bit behind where his sister was in reaching developmental milestones.

The infant in this age range needs caregivers who will talk to her, cuddle with her, protect her, be excited and interested in her explorations, encourage her to explore and be there when she needs them. She needs caregivers who will firmly set limits as necessary - saying no and removing the child from the disapproved of situation is one way, distraction is another way. Fortunately, while others may find the infant less sociable, primary caregivers will often find the infant of this age delighted and delightful.

Another difficult situation that erupts in this period is that of teething which can be painful not only for the infant but for caregivers as well. Beyond some pain relieving attempts such as cold pacifiers, or a medication that helps to numb the gums, the main allies here are time and patience.

Motoric

6-7 months: rolls from back to stomach
sits alone easily
plays peek-a-boo
passes object from hand to hand

8-9 months: pulls to standing
steps when held upright
plays pat-a-cake

10-11 months: walks (with help)

11-12 months: stands alone
drinks from a cup

Transitions

The main transition during this period which will call for changes in parental behaviors is change of the baby from a stationary to a mobile creature. This change demands that parents attend more often and more carefully to the baby. It also means that parents need to rearrange their house in order to baby-proof it. There are several considerations to make. If there are stairs, gates that can close off both the top and bottom may be worthwhile. Anything which can result in items being pulled onto the child's head (such as vases on tablecloths which may be yanked on by a child using it to help her stand up) might be moved. Covers for electrical sockets can be bought. Cabinets can be locked, and all items which can be dangerous if placed in the mouth

ought to be moved. These include not only toxic substances, but also small items that are sharp or that could choke the child.

CHAPTER 3

TWELVE TO TWENTY-FOUR MONTHS

General Comments:

This second year sees tremendous changes in a youngster. Important and quite noticeable differences occur in the areas of: language development, cognitive complexity, locomotion, autonomy and individuation, and attachment. No longer is she an infant, but is passing through toddlerhood on her way to being a full-fledged child. She has significantly developed her personality and her self-concept.

Through this period, a child moves from understanding simple commands and using a handful of words, to someone who may comprehend several hundred words and possibly be speaking in complete sentences. Her understanding of causal relationships, of the permanence of objects, are again increasing in accuracy and depth. From somewhat tenuous steps, the child is now walking and running (waddling quickly might be a better description). She is all over - exploring, testing, examining, investigating.

This year also covers an extremely important period in the child's development. She continues in a thoroughgoing manner to struggle with the twin tasks of autonomy,

individuation and self-concept on the one hand, and attachment on the other hand. Hence the child during this year becomes increasingly attached to her primary caregiver - turning to him or to her for reassurance, comfort, consistency of presence. At the same time the year ushers in the period of negativism. The child learns to say no and comes to like saying it a great deal. She says it when she means yes, when she means no, and at many other possible opportunities. While increasingly attached, the child also struggles for autonomy, to be free of constraints and of controls. There are many battlegrounds for this conflict between the child's needs for attachment and for autonomy. One which often proves difficult begins to be available for combat toward the end of this year - namely control over elimination functions or toilet training.

This is frequently a difficult period for caregivers. The frequent stubborn refusals to comply, and the willfulness, are often threatening to parents who feel that they may be losing control over the child. The confusing demands to be present and caring while allowing for exploration and negative and angry remonstrances, to be flexible while remaining firm, can indeed be stressful. On the positive side, the youngster is also interested and interesting, wanting closeness, and the intense negativism ought to subside after 1/2 year to 9 months or so.

Cognitive

The most noticeable change in cognitive functioning over this period is the emergence of the child as a symbolic, language-rich person. There are also striking changes in the realm of self-concept, and in the concept of object permanence.

Linguistically the child truly blossoms in this second year of life. Particularly in the latter half of this year the child begins to utilize an increasing number of words in ways that are societally understandable. Before this the child probably has a few "words" that are unique to her with which to refer to common objects in her environment. Now however she is beginning to adapt to social usage. By this second half of the second year she already has mastered a lot of the basic syntax or rules that govern how words get put together to make sensible phrases and sentences. With the emergence of a broader expressive vocabulary on top of her syntactic capabilities we see a veritable explosion of language. We also begin to see the phenomenon called rule-governed behavior in speech. The two year old child may call the plural of mouse "mouses", or say "I ranned to the store." This is evidence that she has some mastery over the rules of speech and is applying them broadly. The exceptions and irregularities get learned over time (it is to be hoped).

The second year child is developing a clearer picture of herself as separate from others. As she matures, as her awareness of her body increases through engaging in new activities, as she develops her concept of object permanence and her understanding that objects can have a life of their own, independent of her, as her will begins clearly to clash more frequently with her caregivers', she is developing her sense of herself as a separate human being with her own desires, wants, skills and feelings. Particularly beginning around the second half of this second year the child begins to be able to think in the way that adults mean when they use the term. She begins to be less impulsive, she can figure out consequences of actions more accurately, she can just begin to use language to mediate actions. This is a time when you can virtually see the young child stop, think, figure something out and proceed. Previously she was more likely to give up, cry or try random behaviors.

Social-Emotional

Quite a time this is, for the youngster and her caregivers. As we've seen, the child is developing a sense of being separate from her caregivers, along with the ability to think, and along with a need to ensure that her needs get met and a need to prove and test her autonomy.

During this year the child is learning to rely on others for consistent loving and caring, to be protected, to

learn from those around her. She is also learning that she can rely upon herself for a great deal. The child is developing myriad skills and capabilities of which she is proud and which increase her feelings of self-reliance and potency. These feelings of potency often run into her caregiver's needs to protect her, to discipline her, or to set limits upon her. Thus this period "the terrible twos", or the period of negativism finds the youngster pitting herself against her caregiver's will more and more frequently, and over a tremendous range of experiences. They will frequently say no to something they really want to do, such can be the almost driven quality of the negativistic behaviors. Thus this is a time for the child to learn if she can be a potent individuated human being (in some ways) and also remain loved and secure.

As the period moves along and the child begins to have the capacity for regulating her elimination processes, the struggle for autonomy and adaptation to the environmental and societal demands crystallizes. This can become a struggle for control or it can become a process of mastery and increasing pride-depending upon the child's experiences.

Demands upon Parents

Certainly the demands upon caregivers become significantly broader and more complex during this period. The child, through her increasing cognitive complexity, her

use of language, her increasing awareness of herself as a separate individual, her increasing understanding of causal relationships, can gain a more clearly delineated sense of the effects she has upon others and upon her world in general. Therefore one of the tasks of the caregivers is to help her to clarify this understanding through consistency of rules and consequences for behaviors - both "positive" and adaptive behaviors and "negative" and maladaptive ones.

The task is not simple however because at the same time the child needs to learn that she can make mistakes and disobey instructions without losing her caregivers' love, and that she can be effectual. That is, that sometimes she can have her way despite initial objections by her parents. Thus she needs consistency without rigidity. The youngster needs to be able to "win" (on occasion) in the disputes with grownups where the caregivers deem it advisable and prudent to relent. Disobedience is not "bad". It is a human, natural and healthy part of life. The child needs to be learning the consequences of disobedience that she might, as she ages, understand fully the effects she has upon others, and decide for herself how she wants to act and the sort of interactions in which she will want to engage. Furthermore, by the limit setting and judicial yielding to the child by the adults, the youngster learns to control her impulses and also that flexibility is a positive coping mechanism. She

learns that compromise and mutual adaptation and respect for the needs of others are salient and viable.

An example of the problems that may arise is toilet training. This can be treated as a contest of wills - to "train" the child. It can alternatively be treated as a creative opportunity to assist the child in mastering skills and in achieving the autonomy that is attendant upon increased self-reliance. To do this involves interesting the child in the whole toileting process through discussion, familiarization with the implements (potty), and "dry runs"-as if it were a game. Then gradually, step by step the child can be allowed to practice the skills necessary for mastery, i.e. awareness of bodily sensations of fullness of bladder, control of sphincter and urethra, use of the potty, cleaning herself, etc.

When limit setting, the injunctions and the consequences should be clearly stated and understood. The consequences should be carried out regularly and without shaming, guilt inducing or fear provoking behaviors. Examples of limit setting devices as this period moves on, are removal from the disputed area and confiscation of an object being mishandled.

Motoric

13 months:	throws ball scribbles spontaneously
14 months:	walks backwards uses spoon, spilling only a little
16 months:	stands on one foot with help walks up and down stairs with help removes some clothing
23 months:	stands on one foot alone jumps off floor - both feet together pedals tricycle puts on clothing

Transitions

Of primary importance for a family is the change that leaves the youngster with an increasingly purposeful approach to life. Previously, much of the child's behaviors were reflexive, now they are increasingly purposive (while still frequently impulsive, not thought out). This change often seems to pit the willful child against the demanding parent. The epitome of this struggle is often toilet training, an aspect of life in this period which the child can control by refusing to learn what the parents want them to learn. A suggested way of dealing with this problem follows.

There are many complicated skills necessary for a child to be toilet trained. Some of these are:

(1) awareness of the sensation of bladder and bowel "fullness"
(2) ability to control sphincter muscles
(3) association of toilet or potty with place for urine or feces
(4) understanding of when to start toward potty (interpreting gradations of fullness)
(6) desire to use potty instead of diapers
(7) ability to wipe self
(8) ability to remove and put on clothes by self.

When broken into steps, it becomes clear that there is no monolithic skill that is toilet training, and that the question "when should my child be toilet trained" may not be easily answered. It is possible to help a child become aware of bladder and sphincter fullness and to draw the association with the potty, well before she has the control to actually make use of the information. So around the 17th or 18th month, a parent can start by telling the child he or she is full and letting them see the parent use the toilet. They might ask the child if she is full, and press lightly over the bladder to suggest where she might feel the

fullness. When the parent sees the child defecating or urinating, they could draw the connection to bowel or bladder fullness. To help create the idea of the potty as the place for elimination, a parent can use a doll to show how she could sit on the potty, be wiped and rediapered. This ought to be presented not as a present demand, but as something the child will soon be able to do because she is getting to be such a big girl. This helps foster the child's desire to learn by avoiding the demand characteristics of the power struggle. If the child shows no interest in the process, the parents might want to cease and begin again in two or three months.

When the child has developed the desire, the association with the potty and the awareness of fullness, they need to be able to control their sphincter muscles. This control can be demonstrated and practiced by some kind of game in which the child flexes the muscle. At this point, helping the child learn when to go to the potty by suggesting that she might need to go some time after eating, or when the parent sees the child straining to defecate, might be helpful.

Following this, the parent can help the child learn to wipe and clean themselves utilizing the same principles as above. If the skill is presented as a challenge to master, and as a game to enjoy, the child will want it for herself.

If it is presented as a demand, the child will probably resist.

CHAPTER 4

TWO TO THREE YEARS

General Comments:

This is a period of transition for the youngster. She is becoming a real child instead of a baby. Further developments occur in the areas previously discussed: language, locomotion, understanding of cause-and-effect, social relationships, etc. Two primary areas of development are in the child's orientation toward peers in contradistinction to her earlier nearly total interest in her primary caregivers; and in her development of fantasy and imagination.

The child's cognitive functioning is developing increasing complexity during this period. Her understanding of language is such that by the time she is three years old she probably comprehends much of what will occur for her in normal social discourse throughout her life. Her expressive language is also rapidly increasing. Her cognitions are less rule-governed and literal. She can now make jokes.

One of the most important mechanisms for learning, one of the primary aspects of the human experience, generally finds its development in this year of life. This is the ability to fantasize. While not as extensive as it will

become, the child often enjoys dressing up, or pretending to be some type of person or an animal. Through fantasy the child will gain much - she will practice how to act in social situations, practice using language in different ways, practice and experience how to act in different roles, etc.

The changing social orientation is only beginning in this year. The three year old has become interested in playing with peers. As yet much of this play is parallel in nature (alongside but not cooperative play), and the child still relies greatly upon caregivers for attention and diversion.

Because the three year old is a fairly complex symbol user, interactions with her can increasingly effectively be mediated through language. Limit setting via negotiation and explanations can increasingly take the place of distraction and physical removal. The child is becoming more able to delay gratification.

As the child begins to look more like a miniature adult, as her language becomes more developed and her thinking more complex, the contrast with her still quite primitive (in some ways) understanding of the world becomes starker. The child is quite animistic. She is likely, i.e. to invest inanimate objects with life. Her favorite teddy bear, a jack-in-the-box, falling leaves, might all have some

special meaning for the little pagan. She is also quite egocentric. Despite the burgeoning use of fantasy and the concomitant rudimentary ability to imagine how another acts or feels, as yet the child views the world almost totally from her own perspective.

Cognitive Development

The stage of cognitive development reached by the three year old is quite different from that by the two year old. The differences are as much in the quality of intellectual functioning as in its quantity. For example, the language understood and used by the three year old has multiplied several-fold over the past year to include approximately a thousand words. It may be an even more significant change however, that the way in which the child utilizes language is much more complex. The two year old uses language in a concrete way. The significance of words for her tends to be limited to the verbal expression of physical actions or specific referents. For the three year old words begin to have abstract and conceptual significance and she can begin to play with words and make jokes. The increase in the size of her vocabulary along with the increase in the complexity of her understanding enable the three year old child to be quite the avid consumer of information about the world. In her attempts to ask about and understand that which occurs about her, she is also

engaging with people in ongoing social relationships.

The three year old has begun to have a notion of time and its passing and thus can delay gratification and make plans more than can a two year old.

The development of fantasy life and the increasing ability to utilize her imagination could well be placed under the purview of social-emotional development because it has such widespread implications for the youngster's growth in several spheres. Previously the child was able to imitate, this is not new. What is new is her increasing ability to and penchant for imitating behaviors that are novel to her. Prior to this year most imitation is the mimicry of behaviors that already exist in the child's repertoire. During this year the child increasingly utilizes imitation to greatly broaden her skills. Her use of fantasy encourages her to practice speech. It will aid in the continuation of her differentiation from others and in her learning to take upon herself another's perspective and therefore aid her capacity to outgrow her egocentric approach to the world. Fantasy enables the child to practice many social skills - nurturing, disciplining, cooperating, manipulating, etc. Furthermore it can provide her with an appropriate and socially acceptable forum to express and resolve feelings that arise in her in response to her living situation.

There are definite flaws in the cognitive understanding of a child this age. Animism was mentioned in the general comments as well as egocentrism. This latter may bear some explanation.

In "Children's Cognitive Development" by Ruth Ault the example is given of a two year old girl whose father is distressed because she has been eating cigarettes. Using this example to see how fantasy and the degree of egocentrism change over time, we will begin with a young baby. If she were to put cigarettes in her mouth, it would be as part of her "putting-everything-in-her-mouth" schema. Imitation would play no part in it. By the time the child is two, she may be imitating the actions of a parent whom she has frequently viewed putting cigarettes in his or her mouth. Due, however, to the degree of egocentrism, due to her inability to vie the world from another's perspective, this two year old mentioned in the book assimilated the cigarettes into a behavior pattern already learned and understood - namely eating. She was not yet able to imagine a use much different.

Social-Emotional

In this year the child's negativism ought to dissipate if it has not yet done so. She will still be stubborn at times and clearly have a will of her own, but the almost compulsive quality of her naysaying ought to greatly

decrease.

Her attachment to her primary caregivers ought to be secure and strong. It is now that a trend that will increase over the years, begins. One of the primary social-emotional changes during this third year of life is the child beginning to orient herself more and more toward her peers. As yet her primary social interest is still with her caregivers and will remain so for many years, but she ought now to be showing interest in playing with peers. This play will consist mostly of one-on-one activities rather than group activities (unless otherwise arranged by an adult). It is also primarily comprised of parallel play. This means that rather than cooperative mutual activity the play is mostly side by side, but separate. As her use of fantasy increases and her egocentrism decreases the play will tend to include her peers in an increasingly mutual manner.

With her caregivers the child's relationships are increasingly enjoyable. As the negativism of the previous period decreases, her fantasy, her mimicry, her ability to think, listen and converse make the three year old an increasingly interesting companion.

Demands upon the Parents

This third year of life can be difficult for caregivers. This is generally not due so much to the child

being ornery, in fact particularly in the latter half or so of this year the child can be quite the pleasant companion. Rather, because the child is moving from babyhood to small personhood, it can sometimes be difficult for parents to feel confident that they are accurately gauging the child's levels of capabilities.

Essentially the work for parents during this year is not very different from the last period. The child needs appropriate limit setting, plenty of affection and flexibility. The child however is a little less predictable than she was before. She will not automatically say no to everything. She'll want reasons for most things. Now, along with the limits should come, frequently enough so that the child will learn and understand, reasons and explanations. Rules can be set out in advance with the expectation that the child understand and remember them (Simple rules and for behaviors that arise regularly). Time-out, loss of privilege, removal from temptation, are examples of disciplinary steps for this period. It is important to remember that although the three year old looks in some ways like a little big person, her impulse control is still weak, her understanding of the world is still sometimes surprisingly primitive, so that flexibility and careful observation of how much to expect from the child are called for.

While the three year old child can be delightful to be around and still relies mainly on her caregivers for social connections, she needs to increasingly broaden her scope to include her peers. At this stage this doesn't doesn't entail necessarily being in large groups of other children her age, but it is important for her to have frequent access to another one or two peers.

Motoric

20 months: kicks ball
throws ball overhand

22 months: jumps (both feet off the ground together
puts on clothing
washes and dries hands

24 months: pedals tricycle

25 months: walks up (and down) stairs alone (both feet on each step)

30 months: walks up stairs alternating forward foot

33 months: dresses with supervision

36 months: buttons up

Transitions

Here a common transition is from a single child family to a two child family. This change presents great demands upon both the family as a whole and the two to three year old child in specifics. The parents who had begun to re-establish a routine in which they have some time to

themselves, time to sleep, and a relationship with their child, find that they have less time for each other, and for their child, as the new-born's needs take precedence.

There are several ways to help minimize the rivalry that can develop between the children. One is to prepare the child prior to the birth of the baby for what will be. It is useful to give the child means to be part of the preparations - picking colors of new paint, or making decisions about where the diapers will be put, etc. A second is to minimize the changes and losses that the new birth creates. This includes ensuring that the child is not overlooked when relatives come to "ooh" and "ah" over the infant. A third is to be sensitive to the angry feelings and scared feelings the child will have. It is likely that she will display regressed behaviors such as wanting to drink from a bottle, and to be cuddled, and to sleep with her parents. Parents can help their children by allowing some regressed behaviors and not angrily tell them not to act like babies. A fourth way to help is to give praise and attention to the child for the "grown up" behaviors that they can do and which are special and a big help to the parents. These can include giving them small ways to help care for the new-born. The fifth way is to make sure that they spend regular time with the child, avoiding the natural tendency to have parental time spent on the baby's demands.

CHAPTER 5

THREE TO SIX YEARS

General Comments:

If the previous period (2-3 years) was in some ways the transition period between babyhood and childhood, then this three year period can be considered the transition from early childhood to middle childhood. The three year old child is beginning to find play with others to be increasingly important, yet she still relies on her caregivers and on adults for most of her social interactions, her amusement, and for security. Even when playing with her peers, the activities in which she engages are likely to consist in the main, of parallel play. She tends, in other words, to play next to another child without engaging him or her in much mutual play. The six year old is moving into play not only with a single peer, but with groups of her peers, and the play tends often to be highly cooperative. This play is becoming as important to her as is play time with her caregivers.

The three year old is doing a great deal of experimenting with the world. She tries out various modes of interacting with the environment and learns from the results. She is learning about herself and her place in her

world - how powerful she is, how effective, how likeable. She is extremely inquisitive, yet her questions seem geared more to maintaining contact with adults than to adding to her store of facts. The six year old has a fairly well developed Weltanshauung or view of the world. She has to a much greater degree made up her mind about what the world is like and what to expect from it. Her personality has clearly taken shape. Her questions are geared to expand her knowledge about how things operate in the world.

The child's growth in other areas follow the lines drawn in previous periods. Her vocabulary more than doubles to over 2,000 words and her use of language matures. She is increasingly capable of abstractions. She can count and do small sums. The three year old could button herself, dress with supervision and run somewhat awkwardly. The six year old can skip, run, and throw a ball overhand fluidly. She can button her clothes with ease, help around the house, and prove to be surprisingly reliable. Her sense of humor is keener and she can control her impulses more effectively and for longer durations.

Despite these ways in which she looks like a miniature adult, there are still primitive aspects to her thought. She still finds it exceedingly difficult to imagine another's perspective as being different from her own. She still imbues inanimate objects with life. While she knows

that effects are brought about by causes, she is not selective in considering what causes might bring about which particular effects.

For parents, one of the difficulties of this period lies in its transitional nature. Parents might now be thinking fondly of the early years and how fleeting they were and how adult the child now appears - particularly as entrance into school approaches. The child needs encouragement to grow and to separate from her parents, while not being pushed away too fast, being chastised for her needs to regress at times, or made to feel guilty for her increasing orientation toward her peers. Just as the infant toward the end of the first year needs her parents to encourage exploration while remaining there for consistent support and security, so in the same sense, the child of this period needs to explore peer relations, the world outside the home, in an atmosphere of mutal acceptance and security.

Cognitive Development

The six year old child is nearing the end of what Piaget calls the pre-operational stage of cognitive development. She has a well developed notion about the passing of time and can delay gratification for respectable lengths of time. She can take a break in a game one day and return to it the next. She uses upwards of 2,000 words that

she can utilize with varying degrees of complexity and of abstractness of thought. She understands prepositions and relationships between objects in space and can express those relationships accurately.

Despite her many admirable gains, the six year old (the pre-operational child in general - this stage is estimated to last until around 6 and 1/2 to 7 years of age) has quite a few conceptual gaps. Briefly, a few of these are her egocentrism, her animism, her syncretism, juxtapositions, and tendency towards transduction.

The child's egocentrism and animism have been discussed before. In this stage a child still finds it very difficult to imagine the world as being other than as she sees it herself. She ascribes to others feelings that she would have and she assumes that others perceive what she is perceiving. In being animistic, the child assumes that objects in her world are suffused with life and motivations of their own.

Syncretism, juxtapositions, and transduction are all ways in which the pre-operational child, having learned to draw connections between objects or between concepts, makes errors because she has not yet learned the intricacies of many types of connections.

For example, take cause-and-effect relationships (please). Some children will explain such a relationship by

seizing on some characteristic of each particular case rather than by a logical relationship that would link all individual cases. These children are exhibiting the reasoning flaw known as transduction. An example culled from Beard (1969; pg. 47) follows, "a large boat floats because it is heavy, a small one because it is light, a raft because it is flat, a needle because it is thin." The children are arguing from particular to particular - from one local characteristic of an object to another, without looking for a general relationship (lighter than water, e.g.).

At other times children will coalesce different parts of a situation or of an object with seeming disregard for the relationships that ought to obtain. They put together or juxtapose parts without considering the child to which they belong.

In mistakes involving syncretism, the child creates links for unrelated things because they have somehow found themselves in a related conceptual field.

These are all ways in which children fail to grasp the underlying conceptual framework of a task or of a relationship. They may give a flavor of how the six year old will bravely and confidently explain something yet make numerous incongruous blunders.

Social-Emotional

These too are important years for the child. They represent a transition from caregiver-bound, primitive-thought-bound, relatively impulse-bound child to a more competent problem solving "middle-childhood" youngster. As such these children combine mature and immature behaviors, thoughts, and needs into a confusing amalgam.

The three year old is a very social child, however, many of the interactions occur simply in order to interact rather than for any specific desired outcome. For example, their play, parallel in nature, is not designed to share, cooperate, teach or learn, but rather to coexist and to practice sociability. It is not rare to see three year olds engaging in collective monologues - each orating her own little speech but taking turns talking (not listening, but talking). Many of these inquisitive childrens' questions seem designed not to gain responses but to have a social interation.

The six year old not only plays in groups, the nature of the play itself is quite different. It is characterized much more by mutuality. Tasks are shared, fantasies mutually elaborated upon, problems discussed and solved together. When the six year old asks questions, it is more in the nature of a little scientist trying to understand the world.

Another change involving the social world of the six year old is the balance between her orientation toward peers and her orientation toward caregivers. Many six year olds want to spend much of their free time with their peers, looking to them for a significant part of their entertainment. The six year old is though still ensconced in her family and relies greatly upon her caregivers for time, support, security, and warmth.

The six year old has a fairly well developed sense of self and of her differentiation from others (while still being egocentric). Along with this, and her consequent ability to sympathize, to show leadership, to engage with others in a give-and-take mutuality, she also begins to understand vaguely the possibility of harm to her existence. The five year old may have many vague fears (since so many objects in her world have lives of their own, she can hardly ever be entirely safe from potentially harmful impulses). The six year old may have graduated to specific fears regarding her own death or that of her caregivers.

If the child has not previously been away from her caregivers for any length of time, the prospect of school looms large. It can be both exciting and terrifying, but certainly epitomizes the change from the caregiver-dominated child to that balanced with a tendency toward interaction with the greater world and peers.

Demands upon Parents

The child's needs from her parents are really a recapitulation of what was needed previously. She needs modelling of assertive, social, confident, inquisitive, thoughtful actions. She needs a consistent and understood set of demands and expectations - firm enough to maintain consistency and compel her consideration of them, yet flexible enough to teach her that she can at times be effective in changing her world if she sets about it appropriately. She needs consequences for her actions to be predictable and appropriate. She needs to be able to disobey without being "bad" - just disobedient and therefore liable to suffer the consequences. She needs to be allowed to make mistakes. In other words, she needs to be able to be just who she is withough being squashed for it. This includes her attempts to reorient herself more toward her peers. She needs to be supported in this while at the same time be allowed to be afraid or to regress, to not have to act more mature than she is.

Many parents find the child's entrance into school to be a poignant and frightening time, evocative as it is of the child's burgeoning independence. Often when parents have been staying home with the child, this is a time when reconsideration of the parent's own living habits must be re-examined. The child needs for this to not interfere with

her movement into school and toward peers, or to encourage her own fears of exploration and growth.

Motoric

three and a half years:	dresses without supervision hops on one foot
four years:	draws person displaying three parts catches bounced ball
four and a half years:	balances on one foot for ten seconds draws person displaying six parts walks backward heel to toe

Transitions

Two transitions are of note in this period. One is the family change which comes from having school-age children. It is a change which leaves parents with more time to attend to their own needs. It also can be a time in which parents find it difficult to allow their children to move on easily.

A second transition is an outgrowth of the increased cognitive abilities of the child. This involves changes in the types of disciplining which parents can constructively use with their children: Essentially this is a change from distracting the child and removing temptations to methods

that increase the child's self-control. A good example is the use of "Time-Out" (T/O). Some guidelines for the use of T/O follow.

(1) It can be used with children from the age of about 4 to the age of about 12
(2) an optimum duration for T/O is approximately 3-5 minutes
(3) An ideal setting for T/O is one which is quiet, safe, free from distractions
(4) The reasons for T/O and the rules of time out should be explained clearly to the child. Afterward, when sending a child to T/O there should be little dialogue.
(5) The child should be released from T/O at the end of the T/O period unless she is violating the rules, in which case the period should be extended until the child has been quiet.
(6) T/O should be used consistently if used at all.

CHAPTER 6

SIX TO ELEVEN YEARS

General Comments:

It was mentioned previously that all of these stages have no precise time constraints. Children can enter them and leave them at different ages. Nevertheless, heretofore it was easier to talk about small gains and tasks to learn, and to generalize with some accuracy in predicting when and how normally developing youngsters would attain those skills. As time passes the individual differences that make up each child - their genetic endowment, their environmental factors, their health, their interests, etc.- play an increasingly large role in their development and it becomes less possible to talk accurately and precisely about when a skill will be learned. The time periods to which we refer therefore grow longer, and the changes the youngsters effect become broader and more general.

There are then several broadly defined tasks relevant to the child's development during this period. Cognitively the child is expected to move into the period of concrete operations. This means she will be able to perform several types of problem solving operations which previously she was unable to complete. Primarily she will be able to observe

when a transformation of some objects actually changed it, and when the transformation merely changed its appearance. She will thus be able to, as it is called, "conserve" quantity and number. Academically, she will be learning arithmetic reading and writing.

Socially, the broadly defined task ahead of the child is to learn to live an amphibious or actually, a "polybious" life. What this means is that she needs to develop sets of behaviors that will enable her to function adaptively not only in her family, but also with her peers, and again with school and other outside authorities. She must develop the flexibility to be aware of the differing demands and expectations of her separate worlds, and to work out ways to be successful in having her needs met as fully as possible in each of them. She will be learning how to establish friendships, particularly with same-sexed peers. She will learn to make judgments about herself, to be self-critical, and also to be critical of others including her parents.

Cognitive Development

There are two basic ways in which cognitive functioning changes in this period. One is in the nature of what the child is capable of understanding. The other lies in the new focus on mastering bodies of facts or intentional goal directed learning (not surprising as this occurs during school years).

The youngster's cognitive processes reach a new stage early in this period as she enters the concrete operational stage. Essentially this refers to a number of "operations" or thoughts about some ways in which objects in the world are manipulated, that she can now understand and which enable her to accomplish tasks that were previously beyond her capabilities. Three such operations are negation, reciprocity and identity. In brief, these respectively suggest that she can a) observe when a process can be reversed or negated (such as pouring a liquid back and forth between differently shaped vessels), b) observe that changing one aspect of form may lead to a related and reciprocal change upon another aspect (increasing the length of something may decrease its width), and c) if nothing is added or subtracted, quantity must remain the same. These operations enable the child to "conserve" quantity, number, liquid, etc. This in turn enables the child to master arithmetic operations.

What these children cannot yet do is perform these operations upon hypothesized illogical problems. Should they be asked for example, how many noses six children would have if each had three noses, they would likely insist that children have only one nose each rather than perform the necessary calculations.

The second change involves the tasks given to the

school attending child. She is assigned facts to memorize, concepts to master and skills to learn. This usually is a period in which the child enjoys problem solving, and the amount of knowledge assimilated during this period can be astounding.

Social-Emotional

In this social-emotional sphere, the child is extraordinarily busy. Her tasks include learning how to engage with her peers in an increasingly mutual fashion, in relationships of greater duration, and how to choose from among her peers those whose interests and attitudes are congenial to hers. She struggles to gain an increasingly deep broad and accurate picture of herself - her skills, strengths and weaknesses. She learns that parents are not omniscient nor are they infallible. She creates a balance between assertiveness with authorities and acquiescence when necessary.

There are many steps along these paths and they are not inexorably ascendant. Certainly the child's self-concept and self-esteem undergo ups and downs in this period. A frequently found pattern involves moving from an early pride in accomplishments and in the newly found sense of being grown-up that can come from beginning school. The new demands, from peers and school, with grades and reports and criticisms and competition often lead to a drop in

self-esteem and loss of confidence. Soon these children may have begun to develop a more judicious critical faculty about themselves and be less distraught by their shortcomings. This acceptance may continue and expand until a prepubertal eleventh year rocks the boat. This year is another transition year, beginning the movement into puberty and adolescence. The typical eleven year old may again be highly sensitive to slights, offenses and neglect, having her stress levels rise and her confidence in herself shaken.

Interactions with caregivers have a similarly varied pattern through this period. Often there is a change as the self-centered attitude of the six year old may shift somewhat and the child may be more interested in helping around the house and exhibiting a greater interest in others. This coincides with the developing critical approach to herself and others mentioned previously. Thus an eight year old may be starting to relate to other, including her parents, in a more critical way, being alternatively critical, loving and scornful. This new mode of seeing others and relating to them generally matures to be a more balanced approach to the parents, again until the fateful eleventh year in which many children engage in struggle and defiance to establish autonomy and combat against imagined or real slights.

Peer relationships may exhibit more consistency.

Essentially they tend toward greater reliance upon friendships, more mutuality and increased selectivity based upon common interests rather than mere propinquity.

Separately, the child's sense of morality undergoes shifts in this period. At first her assessment of "badness" is based upon the quantity of damage caused. Later it becomes based more upon intention. For example, at first a child who made up an impossible story might be judged to have done something worse than a child who lied by claiming that she had done something which she could conceivably have done but had not. This would be based on the fact that one's story was impossible while the second's was merely untrue. As the child progresses, the intent, to amuse or to deceive will be more salient in her judgment of "badness."

CHAPTER 7

TWELVE TO SIXTEEN YEARS

General Comments:

While adolescence does not end in our society at sixteen, telephone services of the type for which you are being trained rarely receive calls about children sixteen or above, so this manual will end with this period.

He who said that "adolescence is not age, it is a diagnosis" is not far wrong. During adolescence several powerful forces in the life of a youngster merge, as if three rivers converged at a single point and their confluence continued to rush on in an exceedingly turbulent fashion.

These singularly important aspects of adolescence include; the development of formal operations in the cognitive sphere, the physical maturation that results from the onset of puberty, and the approach of adulthood and consequent need for the adolescent to become independent and competent. Each of these has ramifications that go beyond their narrower impacts and the interplay of them exacerbates their individual effects.

In the cognitive realm the youngster moves from the period of concrete operations to the stage of formal

operations. Now she can perform mental manipulations upon purely imagined and non-existent objects (if A is bigger than B, and B is ...). She is no longer bound by the observable and can imagine the world being different than it actually is or appears to be. Finally, the adolescent is able to put herself within another's perspective and seriously examine herself as she appears to her world.

Partly as a result of these changes, we see the world and compare it to what should be. She makes judgements about society, about parental beliefs, and about how closely her parents hew to the beliefs they profess. She also develops that adolescent self-consciousness with the tremendous preoccupation with how she is perceived - her appearance, as well as her inner self.

While sex differences exist throughout life, they become especially important now. With the advent of the development of secondary sexual characteristics and the growing significance of other sexual relationships, boys and girls have in our society some clearly differing patterns of responses. Instead of dealing with all of these however, we will consider the general demands of adolescence. As a result of puberty, new stresses, new demands, new feelings and desires, new concerns, begin to quickly surface. Now at the same time that children are able to imagine perceiving the world from another's perspective, thus being able to

imagine how others view them, they are intensely interested in other's approval of them and they are rapidly changing in appearance as well (girls sooner than boys and all of them sometimes too rapidly and sometimes too slowly to suit). Boys' bodies are becoming more muscular and more powerful. Girls' bodies are becoming rounder and fatter and curvier with noticeable breast development which can be a matter of both pride and embarrassment. The desire for intersexual (though not necessarily sexual) relationships increases and those who are not ready as well as those who are, suffer worry and anxiety about their popularity, their acceptability, their very selves. Decisions about sexual activity and its value as an acceptance factor often stir powerful feelings that disrupt their lives.

The third general aspect of adolescence is the movement toward autonomy or control of their own lives. The ambivalence of this is noteworthy, with the decreasing desire to be protected and the decreasing fear of self-reliance competing strongly with the ascendant push for autonomy. This struggle finds expression in nearly all parts of the adolescent's life - sexual activity, drug use, political beliefs, relationship with parents, choice of friends, school functioning.

The synthesizing theme for adolescence is the definition of the self or the creation of identity. It is

the delineation in a more mature and cohesive and well understood way than before, of the beliefs, cognitions, behaviors and the like that comprise the person.

If adolescence is like a maelstrom, all around are often pulled or jump voluntarily into the eddies. Parents frequently find this time to be the most frightening, enraging, sad period in their relationsips with their children. Their control over their adolescents' lives is slipping away, the peer group is maintaining an increasingly strong effect upon their children. The adolescent in only a few short years from separation physically from the parents.

The new attempts to be autonomous are frequently very threatening to the parents - involving a seeming (or real, if possibly temporary) rejection of the values and beliefs of the parents in drug use, sexual activity (particularly distressing in our society to parents of girls), `decadent' forms of music (also loud), political fervor. Nevertheless, most parents of adolescents report basically favorable relationships with their children.

Cognitive Development

The basic change in the thinking processes that takes place near to the beginning of adolescence, that which describes the movement into the formal operations stage, is the new ability of the adolescent to perform calculations and mental manipulations upon imagined, hypothetical and

figurative objects.

This development has many ramifications. It enables the youngster to take another's perspective which leads them to see themselves as other view them. It increases their problem-solving skills manyfold because it allows for hypothesis creation and testing. Now the adolescent is able to imagine the world being different, allowing for comparisons of the world as it exists with her ideals, as well as comparing how the world appears with how it is. These lead to critical appraisals of parents, teachers, peers
and self.

The adolescent, then, suddenly finds herself in a position to question that which is going on about her. She often begins to look at the correspondence between what her caregivers or other authorities say and what they do. This is often a time in which idealism and rejection of what they perceive as hypocrisy have an important role in the adolescent's life.

The ability to view the self as others do has a powerful effect upon the adolescent occurring as it does at a time when appearance and acceptability to peers is becoming especially important and attraction by and to the other sex is newly important and stressful. Furthermore it occurs at a time when much of how the individual has

presented herself to the world and to herself is changing. This will be discussed at greater length in the next section.

The adolescent's ability to problem solve takes a big leap at this time. The scientific method and objective appraisal of situations call for both the ability to create a hypothesis and compare it to the available facts and if necessary, set aside the hypothesis in favor of a new one. They also call for fluid synthesizing and differentiating on the basis of more than one factor. In other words it is necessary to be able to look at how things are similar and how they differ, and to do so on the basis of more than one characteristic. This, and the ability to hold in awareness how things may differ and yet be similar at the same time, on different dimensions, develop during adolescence.

Social-Emotional

Adolescence is a turbulent time for the development of peer relationships, relationships with parents and other authorities, self-definition, autonomy, etc.

The drive for autonomy becomes increasingly forceful during this period, fitting in with the adolescent's creation of an identity and with her impending separation from her family of origin. Identity is based upon beliefs, values, and behaviors that characterize the individual. It is during adolescence that testing of these occurs more

regularly. The adolescent is less dependent upon her family for approval, and less isolated from other perspectives and value syustems. Through examination of one's beliefs, thorough observation of how one's behavios affect one's worlds - peer, family, school, and community - this testing takes place.

The period is one frequently characterized by tremendous self-consciousness. The young adolescent is aware now of how others may be viewing her, and is particularly sensitive due to some rapid and emotionally charged changes occurring. For boys the physical changes occurring at puberty can be embarassing for the voice change, and the frequent erections can be disturbing. Generally, however, the changes are viewed positively. Boys become more muscular, more powerful and more "virile". For girls the changes are often viewed more ambivalently. Menstruation is often considered dirty, unclean - the curse. Often the ramifications and the meaning of menstruation have not been discussed with them. The physical changes lead to development of breasts and hips, changes that leave the girls open to attentions, looks, comments and advances with which they may be entirely unready to cope. The physical changes leave them with a rounder, less slim appearace at odds with their previous body image and at odds with a societal ideal of slimness. Additionally the expectations

of many parents is that as girls reach puberty they ought to give up athletics, competing academically and the range of "unladylike" behaviors. This can remove sources of pride and accomplishment. Thus for many girls the negative aspects of the onset of puberty may equal or outweigh the positive.

Demands upon Parents

Parents of adolescents need to be very flexible. It behooves them to accept the fact that their children need more and more to make decisions for themselves about values, friends, choice of occupations and so forth. At the same time both for their own sakes and that of their children, firm rules and expectations need to be maintained. At all ages children need firm limits to protect them from their own impulses and uninformed desires, and this is never more the case, perhaps, than at adolescence. Early adolescents in particular are confronted with choices and pressures for which they have not the inner resources to cope. They have not yet developed a clear identity to help them judge how to behave and to resist the pressures and temptations that exist. It saves them from stresses and pressures to have clear expectations to which to adhere and against which to struggle.

Besides clear consequences for disobedience, parents ought to pick their battles carefully. to this end, they

need to know their children such as how trustworthy they are. They also need to realize that children struggle against their parents yet still need them and will continue to do so. Firm limits without rejection, and acceptance of the adolescent's need for autonomy without permissiveness, can help.

If parents have been handling their children consistently over the years, with firm limits complementing judiciously allowed freedoms, adolescence can be a time characterized by parents and adolescents cohabiting in relatively harmonious ways.

Transitions

Again, in this period, there are a variety of transitions for the family of adolescents and for the adolescents themselves. For parents, the transitions include needing to use new styles of disciplining, allowing their adolescents to claim increased autonomy, and allowing them to leave the family as young adults. Here we will discuss ways in which parents can discipline their adolescents.

As children move into adolescence, parents need to move from unilateral methods such as Time Out or charts, and toward methods of greater mutuality such as negotiation and compromise. This means that parents need to choose more carefully what issues they cannot compromise on, and

negotiate on other matters. Additionally, parents can at this time negotiate with their adolescents on details of rules, e.g., bedtime or curfew hours, types of dating activities sanctioned. This allows the adolescents to feel that they have greater reason to obey family rules, and also enables them to learn how to take responsibility for themselves.

APPENDIX B

Child Development Questionnaire

CHILD DEVELOPMENT QUESTIONNAIRE *

Please circle the letter that corresponds to the best answer:

1. The incisors, good for biting, begin to appear at about the age of:
   a) 3 months; b) 7 months; c) one year; d) 18 months

2. The introduction of solid foods before three months:
   a) is safe if limited to potato and gravy; b) may place strain upon the kidneys; c) provides a good supplement to the breast or bottle; d) has no relation to obesity later in life

*3. Studies indicate that when mothers and and children are at home all day, with no other company, children are more likely:
   a) to cry to distress; b) to develop little stranger anxiety; c) to show great interest in the environment; d) to be rejected

4. It is thought that an infant is ready to make his first attachment to a specific person:
   a) at birth; b) in the second quarter of the first year; c) within 2 or 3 days; d) within 2 months

5. At what age do babies normally begin to smile at human faces?
   a) 5 or 6 weeks; b) 3 months; c) 6 months; d) none of these

*6. The following statement is true:
   a) the sooner toilet training is begun the less time it will take; b) punishment and scolding decrease the time of toilet training; c) a good time to begin toilet training is after the child's second birthday; d) children trained after the age of 20 months tend to learn quickly

*Note: Starred items had zero variance on the pretest.

*7. T/F Usually abusing parents were abused themselves

8. What is the most frequent cause of death for young children in the United States? a) pneumonia; b) accidents; c) cancer; d) drowning

9. T/F Most two year olds can name pictures or drawings of familiar items.

10. T/F At four, children can understand yesterday and tomorrow very well.

11. For normal personality and cognitive development of children of working mothers: a) mothers should be employed part time; b) parents do not have to interact frequently with their children; c) substitute care must be stable and stimulating; d) it is necessary that fathers not leave the household

12. T/F Television has not been found to contribute to fears in young children

13. When concepts of death were explored in a group of children between sex and fifteen, 3 levels of thinking emerged. On the most immature of these levels, almost half of the subjects described or explained death as: a) the result of illness; b) in connection with weapons or assault; c) accidental; d) reversible

14. A factor significant for school readiness is: a) a body of knowledge; b) physical development status; c) reading readiness; d) all of these

15. The nature and patterning of a particular learning disability can often be linked to: a) the home; b) a certain type of brain impairment; c) lack of motivation; d) feelings of inferiority

16. T/F No causal link has been found between childrens'watching violence on TV and later aggressive behavior

17. Best friend relationships between the ages of

thirteen and eighteen become:
a) more stable; b) less stable; c) very superficial; d) rather fluctuating

18. T/F It has been found that amiable relations between parents and adolescents are the usual situation

*19. T/F Children seldom feel guilty or responsible for a divorce

20. T/F Research has confirmed the common belief that parents should stay together for the children

21. T/F Mothers are more often child abusers than fathers

22. T/F Hyperactivity is easily cured by the administration of medication

*23. When someone close to a six year old child dies, parents can be most helpful if they:
a) don't have the child attend the funeral; b) encourage the child to ask questions; c) hide their own feelings of grief; d) spare children the mourning process

*24. Severe reactions to separation are found among children who are:
a) left in their own home; b) told they will go to a strange place and then go there; c) given information about their parents' leaving and returning; d) socially inhibited or shy

*25. In which of the following situations would an 18 month old be least distressed when left by his/her mother?
a) the child is left with a next door neighbor and her two children whom he/she knows; b) the child is told where the mother is going and how long she'll be gone; c) the child is taken to the home of a new sister-in-law; d) the mother has gone to visit a nearby friend

*26. The most important factor in a child's early socialization experience is the child's:
a) peers; b) family; c) culture; d) socioeconomic class

27. It has been found that in families where the parents were divorced:
a) children of all ages felt responsible for the divorce; b) children did better if they stayed with their mother; c) adolescents could be most objective and see that divorce might be best at that time; d) preschool children could cognitively understand the divorce

28. When children first learn that their parents are going to separate, their first reaction is usually:
a) relief; b) denial; c) hope of reconciliation; d) a desire to get back at the parent who leaves

*29. Ways of coping with the father's absence from the home include:
a) allowing the mother to find satisfaction in her job; b) making adequate counseling available to the mother; c) providing the children with adequate male substitutes; d) all of the above

30. Children who have the best chance of adjusting to the divorce of their parents are children who:
a) remain with their mother; b) remain with their father; c) were the best adjusted before the divorce; d) refocus their attention onto the family and away from their peers

31. T/F There is a higher incidence of child abuse among mothers of premature infants

*32. T/F Maternal employment has a negative effect on all children

33. T/F Infants develop stranger anxiety when they are between ten and eleven months of age

34. In order to develop intellectual and language skills, infants need:
a) to initiate bonding behaviors; b) visual stimulation; c) verbal stimulation from a parent; d) to hear music

35. Most studies on maternal employment show that:
a) it has no ill effects on children; b)

nonemployed mothers are more attentive to their children; c) quality rather than quantity of contact is most important; d) all of the above

*36. A symptom that may be a sign of emotional problems in infancy is when a child:
a) does not explore or show any interest in his/her surroundings; b) cries when approached by a stranger; c) shows anger at around two or three years of age; d) all of the above

37. T/F Studies have found that abusive parents tend to be socially isolated within their communities

*38. Parents can improve their children's ability to cope by:
a) trying to spare them any trauma; b) protecting them from problems until adolescence when they are better able to withstand pressure; c) intervening in their behalf when problems with peers arise; d) allowing them to suffer some pain and anguish

39. The first effort to be made upon discovering child abuse should be to:
a) remove the child from the house; b) remove the abusive parent from the house; c) protect the child; d) begin family therapy

*40. The cause of a learning disability may be:
a) neurological; b) emotional; c) the result of faulty early learning; d) anyone or a combination of the above

41. Which of the following children will be most ready for a preschool or kindergarten experience?
a) Brad is constantly asking those around him why this is so or what does this do; b) Philip is happiest when his mother ties his shoes or colors his pictures because she does them so much better and faster; c) Kelly's parents are so conscientious that they have never left her with a baby-sitter; d) Polly has more toys than any other child so she doesn't have to play with anything for a frustrating length of time

42 Children's utterances are intelligible even to strangers about 80% of the time at:
a) 3 years; b) 4 years; c) 30 months; d) 2 years

*43. It has been found that the most effective procedure for changing an infant from the crying or a sleeping state to the alert inactive state was:
a) cradling baby in a nursing position; b) holding the infant to the shoulder and supporting its head; c) holding the infant on the hip; d) holding the infant in a sitting position

44. The first month of life is a time when the infant:
a) exercises innate reflexive behaviors; b) engages in reflexive behavior that doesn't change; c) shows the beginning of reversibility; d) starts to recognize his/her mother

45. T/F Most children are bladder trained by the time they are three years old.

46. In applying the milestones in motor development to an individual child it is important to remember that:
a) a child who matures early in infancy will do so throughout childhood; b) early development in all areas is advantageous; c) the average time at which a child masters a task has a large range; d) in early childhood the main growth takes place in the bones and muscles

*47. An appropriate age for a child to receive her or his first tricycle would be around:
a) three years old; b) eighteen months old; c) four and a half years old; d) two years old

48. Normal infants need from _____ hours of sleep per day for the first six months:
a) 12 to 14; b) 13 to 18; c) 15 to 20; d) 17 to 22

*49. The introduction of solid foods into an infant's feeding schedule:
a) should begin later with bottle-fed babies than with breastfed babies; b) is usually done one at a time to determine if there is any allergic reaction; c) is known as weaning; d) begins around ten months of age

50. Children should have three daily servings of which of the following major food groups?
a) milk; b) meat; c) fruits and vegetables; d) grain

*51. The father's role in child rearing:
a) should be greater with sons than with daughters; b) should enable him to feel that he can take care of his children by himself; c) should be initiated to alleviate his feelings of resentment toward the newborn; d) should be secondary to the mother's

52. A smile:
a) never has the same meaning; b) is meaningless; c) can have many different meanings; d) always has the same meaning

53. At first, during the first few months of life, fear occurs mainly as a result of:
a) a sudden change in stimulation level; b) specific losses; c) specific individuals; d) strangers

*54. When we view the family as a system, we realize that:
a) everything the family does together is orderly and systematic b) there are many children in the family; c) strain or release in one part of the family will affect the other parts

55. Two children of the same parents are so physically different because:
a) the environment affects each person's basic physical makeup in drastically different ways; b) first born children are treated much differently from second born children; c) each child inherits only half of each parent's genes; d) all of the above

56. Women who are 35 years of age or older are

more likely than younger women to experience: a) longer labor; b) more difficult labor; c) more illness in pregnancy; d) all of the above

57. Newborns who suffer conditions such as disturbed sleep habits, premature birth, microcephaly, and a variety of physical deformities may do so because the mother: a) ingested pentabarbitol; b) experienced emotional stress; c) was a chronic, heavy drinker; d) none of the above

*58. T/F An infant who is significantly premature and low in birth weight even for his or her gestational age faces a more serious risk than an infant of the same gestational age whose birth weight is age appropriate

59. If male and female infants are compared, it will be noted that females: a) develop more rapidly; b) are heavier; c) are more variable in their physical growth; d) have proportionately more water in their bodies

60. Investigations of motor skills such as walking show that; a) specific training can facilitate the early appearance of such abilities; b) even if one child walks significantly earlier than another, this does not mean that the early walking child will have more conceptual intelligence during the early school years; c) grossly restricting a child's opportunity for motor development can retard the time at which a skill is first exhibited; d) all of the above

61. The amount of vocalizing or babbling: a) by an infant is predictive of when the child will begin to speak; b) before 6 weeks of age is thought to be governed by environment as opposed to heredity; c) in a 12 week old child can be increased by speaking to the child; d) all of the above

62. Which of the following statements most accurately describes infants' visual capabilities with a few days of birth? a) they can see light, dark, and color b) they

have poor visual acuity; c) they are incapable of tracking moving lights; d) they can focus on objects at varying distances

63. T/F When infants are excited they usually vocalize

64. T/F In most cases it is possible to predict what a one year old will be like from his or her characteristics as a newborn

65. T/F Newborns can quickly learn to recognize their own nursing mother by the sense of smell alone

66. T/F Maturation does not cause a psychological function to occur, it only sets limits on the earliest time of appearance

67. T/F Differences in temperament among infants can be observed during the first days after birth

68. The appearance of stranger anxiety and separation anxiety is due, in large measure, to:
a) lack of security in the attachment to the caretaker; b) the assimilation of a discrepant event; c) the maturation of new cognitive abilities; d) child-rearing practices

69. Hyperactivity, impulsiveness, inattentiveness, and motor clumsiness are called:
a) signs of academic retardation; b) central nervous abnormalities; c) hard signs; d) soft signs

70. Compared with other parents, the mothers and fathers of aggressive children:
a) usually ignored their children during aggressive outbursts; b) were likely to encourage dependent behavior; c) were inconsistent in their handling of the aggressive responses; d) none of the above

71. Research on the effects of rewards and punishments on aggression indicates that:
a) they have little long-term effect on aggression; b) only verbal aggression can be

easily modified; c) punishments, but not rewards, affect the generalization of aggressive acts; d) rewards and punishments can be used either to increase or decrease aggression

72. Referrals to psychiatric and psychological clinics tend to peak for children:
a) 2-3 years old; b) 12-13 years old; c) 14-16 years old; d) 7-9 years old

73. Jane doesn't want to go to school. This is a relatively common childhood fear and can generally be traced to:
a) separation anxiety stemming from dependency problems; b) a lack of socialization; c) a fear of the appearance of a tic; d) a fear of failure

*74. It has been found that the most mature, competent, independent, affiliative children were raised by _____ parents:
a) authoritative; b) authoritarian; c) permissive; d) autocratic

75. Between the ages of 10 and 14, childrens' groups become:
a) less cohesive; b) more highly structured; c) less important to the socialization of the child; d) all of the above

76. Youngsters below the age of 4 show prosocial behaviors such as sharing, nurturance, and helping:
a) relatively rarely; b) only after such behaviors are modeled for them by their parents; c) more frequently than children of 8-10 years old; d) in their everyday lives more frequently than they do in laboratory settings

77. In elementary schools, boys:
a) have more adjustment problems than girls; b) who are taught by females do better in reading than those taught by males; c) are more motivated to do well than their female peers; d) all of the above

78. In terms of sexual maturation:
a) boys begin developing at different ages; b)

boys usually finish maturing before girls; c) the rate and onset of development differs greatly from individual to individual; d) there is more variation in the rate of development of males than females

79. A majority of girls view maturation as either negative or at best neutral. This attitude is in large part a result of:
a) hormonal influences of mood; b) the negative attitudes of others toward menstruation; c) actual physical discomfort; d) greater need for dependency by girls

80. Emergence of formal operational thought enables the adolescent to:
a) accuse parents of hypocritical inconsistencies between professed values and actual behaviors; b) increase the quantity of fantasy; c) learn foreign languages more quickly than before; d) all of the above

81. Which of the following reflects the "new morality" among contemporary adolescents?
a) significantly more premarital intercourse than adolescents of five years ago; b) mutual respect and lack of exploitation; c) negative feelings and anxiety over having intercourse; d) all of the above

82. In regard to their first sexual experience most females:
a) report generally positive feelings about the event; b) do not use any form of contraception; c) are disappointed because of a lack of a longstanding commitment on the part of the male; d) report using the condom as the contraceptive method

83. The adolescents who use the more serious drugs frequently or who use many such drugs are likely to be: a) from deteriorated urban ghettos, not affluent suburbs; b) from affluent suburbs, not deteriorated urban ghettos; c) those young people who are socially alienateo and psychologically disturbed; d) well-balanced, contented young people with an active curiosity

84. In comparison to those without a drinking

problem, adolescent problem drinkers:
a) valued independence less; b) valued achievement more; c) were more likely to be involved with other drugs; d) were more likely to disapprove of the concept of adolescent drinking

85. The single indicator that most accurately predicts adolescent delinquency is:
a) IQ; b) the young person's relationship with his or her parents; c) the young person's relationship with his or her peers; d) whether the young person comes from a broken home

86. Parents of young children who eventually become delinquent:
a) use severe physical punishment rather than reasoning to discipline their children; b) expect too much of their children; c) are overprotective; d) do not provide sufficient toys and other material possessions for the child

88. Adolescent suicide:
a) is more common before age 15; b) is more frequently attempted by females; c) is rarely attempted by one who talks about it; d) is more frequently completed by females

88. Anorexia nervosa is more common among:
a) boys than girls; b) affluent than disadvantaged children; d) poor students than good students; d) all of the above

89. T/F Marijuana has been tried by more adolescents than any other drug, including alcohol

90. Essay Question:
If you were expecting a week-end visit from a friend with a ten month old son, what stage of physical maturation would you expect to see in the child? Include locomotion, teething, height and weight, and physical abilities in your answer. What safety precautions would you take in preparation for the visit?

APPENDIX C

CDQ clusters and item-total correlations

CDQ Clusters and item-total correlations

Pre-test

Cluster 1: Cognitive/Physical development:

Alpha = .45

Abreviated item title:	Item-Total Correlation
8. Most frequent cause of death	.23
15. Learning disabilities	.08
41. Preschool readiness	.02
45. Bladder training- time of	.23
46. Motor milestones- variation	.15
55. Children of same parents different	.15
56. 35 year old pregnant women- difficulties	.24
59. Comparison of male and female infants	.26
60. Investigations of motor skills show	.26
61. Amount of vocalizing	.21
63. When infants vocalize	.04
64. Prediction of characteristics	.09
66. Maturation and appearance of functions	.06

Cluster 2: Caretaking and Single Parent Issues :

Alpha=.38

Abbreviated item title	Item-total Correlation
20. Parents should stay together	.11
27. Families where parents are divorces	.35
30. Children who adjust to divorce	.11
35. Studies on maternal employment	.28

Cluster 3: Psychopathology : Alpha = .42

Abbreviated item title	Item-total Correlation
72. Referrals to clinics peak at age	.15
73. Jane doesn't want to go to school	.14
84. Adolescent problem drinkers	.16
85. Prediction of delinquency	.45
87. Adolescent suicide	.21

Cluster 4: Adolescence/Sexuality : Alpha = .59

Abbreviated item title	Item-total Correlation
78. Time boys begin maturing .51	
79. Girls view maturation as negative	.32
80. Emergence of formal operations	.33
81. The new morality	.26
82. First sexual experience of females	.30

All items in previous clusters recombined into one

Total cluster : Alpha = .45

Abbreviated item title	Item-total Correlation
8. Most frequent cause of death	.35
15. Learning disabilities	-.01
41. Preschool readiness	-.16
45. Bladder training- time of	-.00
46. Motor milestones- variation	.25
55. Children of same parents different	.31
56. 35 year old pregnant women- difficulties	.33
59. Comparison of male and female infants	.29
60. Investigations of motor skills show	.24
61. Amount of vocalizing	.14
63. When infants vocalize	.02
64. Prediction of characteristics	.12
66. Maturation and appearance of functions	-.01

20. Parents should stay together	.01
27. Families where parents are divorces	.34
30. Children who adjust to divorce	.11
35. Studies on maternal employment	-.09
72. Referrals to clinics peak at age	.08
73. Jane doesn't want to go to school	-.08
84. Adolescent problem drinkers	-.24
85. Prediction of delinquency	.16
87. Adolescent suicide	.28
78. Time boys begin maturing	.24
79. Girls view maturation as negative	-.12
80. Emergence of formal operations	.33
81. The new morality	.26
82. First sexual experience of females	.30

CDQ Post-test: All items from previous clusters combined into one cluster

Total Cluster: Alpha = .01

Abbreviated item title	Item-total Correlation
8. Most frequent cause of death	zero variance
15. Learning disabilities	-.10
41. Preschool readiness	-.30
45. Bladder training- time of	.26
46. Motor milestones- variation	.15
55. Children of same parents different	.10
56. 35 year old pregnant women- difficulties	-.04
59. Comparison of male and female infants	-.31
60. Investigations of motor skills show	.33
61. Amount of vocalizing	.15
63. When infants vocalize	.10
64. Prediction of characteristics	.01
66. Maturation and appearance of functions	.00
20. Parents should stay together	-.23
27. Families where parents are divorces	-.03
30. Children who adjust to divorce	zero variance
35. Studies on maternal employment	-.05
72. Referrals to clinics peak at age	-.05
73. Jane doesn't want to go to school	.00

84. Adolescent problem drinkers	-.08
85. Prediction of delinquency	.13
87. Adolescent suicide	.05
78. Time boys begin maturing	-.17
79. Girls view maturation as negative	-.10
80. Emergence of formal operations	.14
81. The new morality	-.04
82. First sexual experience of females	.25

APPENDIX D

Parenting Skills Questionnaire

Parenting Skills Questionnaire

1. Children maintain their behaviors because _____.
2. Children learn by experiencing consequences, positive and negative. They also learn through _____.
3. Define reinforcer. Explain its effects.
4. Parents need to set limits and to discipline, but _____ is also a crucial part of the learning process.
5. Give two examples of social reinforcers.
6. Give two examples of non-social reinforcers.
7. What type of setting is good for timeout?
8. Timeout can effectively be used for children between the ages of _____ and _____.
9. When reinforcers do not occur behaviors tend to _____. Explain.
10. Yelling at a child can be either a positive reinforcement or a punishment. T or F? Explain.
11. A friend asks you to help him establish a "star-chart" for his son's forgetting to brush his teeth, to his homework, and for teasing his brother. What major steps would you take?
12. For greatest effectiveness, what is a good length of time for timeout periods?
13. Define punishment. Explain its effects.
14. Define negative reinforcement. Give an example.
15. What are several potential problems with use of spanking or yelling or nagging?

16. Children learn best when rewards are _____, _____, and _____.

17. You should always let a child out of timeout when his/her time is up. T or F? Explain.

18. If a child in timeout asks about why he is in there or for how long he must remain, you should calmly answer the question. T or F? Explain.

19. Define modelling and briefly discuss its implications for parents.

20. Lois isn't doing her chores at home. According to social learning theory principles, what would you hypothesize about the reasons?

21. Parental consistency in limit setting and disciplining teaches children not to be flexible. T or F? Explain.

22. You are using a timeout schedule to decrease your daughter's habit of taking away her brother's toys. Along with decreasing this behavior you might also want to _____. Explain.

23. What important thing can you do to help a child learn complex behaviors? Give an example and briefly describe.

24. After a child on a "star chart" has improved for a week, _____. Explain in some detail.

25. Set up a "star chart" system for a whiny seven year old boy. Explain in some detail. Draw a picture of the chart.

26. Set up a timeout procedure for eliminating temper tantrums by a four year old girl. Explain.

27 Describe progressive steps in a child's learning to be toilet trained.

APPENDIX E

Assessment Measure: Protocols and Scoring

ASSESSMENT: Bedtime protocol

Father - 30 years, lawyer
Mother - 28 years, housewife (caller)
Josh - 3 years - problem (not in nursery school)
Amy - 8 mo (2 children share a room)

Presenting Problem

Parents have a hard time getting their son to bed/sleep at night. Josh makes all kinds of excuses to stay up: Finishing a T.V. program or picture he is coloring. Once he is in bed, he finds reasons to get up: bathroom, glass of water, a strange noise.

Solution

Mom lets son finish what he is doing then ends up laying down with him until he goes to sleep. She will also go to sleep with him if he wakes up in the middle of the night and wants her.

Frequency

It happens almost every night, and has been going on for 7 to 8 months.

Typical scene

At first bedtime call, Josh just doesn't listen then starts whining if you keep after him. He says he wants to do such and such. Mom then says OK to what he wants. Finally he gets into bed then is up again a short time later.

Father

He has to get up for work in the morning so he lets his wife take care of Josh when Josh wakes up. At bedtime, he is either working in his study or he tells Josh to listen to his mother. Also, father doesn't have time to get involved with the children. He is busy at work and tired when he gets home.

Bedtime Protocol

Daytime situation

Josh has some friends in the neighborhood that he plays with. He has toys in the house but usually doesn't play with them.

Mom

She hasn't had much time since Amy was born, she has trouble keeping the house clean, and dinner is often late. She feels hassled.

Marriage

They haven't gone out much since Amy came. Dad is busy/concerned with new responsibilities and cases at work. There is not much communication. They have had sex once or twice since the baby was born. Before it was 2 or 3 times a week. Sex was painful after birth so she put her husband off. Sex never increased in frequency after she felt better.

Other

Amy was planned. Mom has a college degree in math and worked for several years before her children were born.

Bedtime Call: Scoring

	Importance
I. A. Who is in family (Presence in/out of home)	
1. father	3
2. mother	3
3. son	3
4. daughter	5
B. Names	
1. father	2
2. mother	2
3. son	2
4. daughter	2
C. Ages	
1. father	3
2. mother	3
3. son	4
4. daughter	4
B. Grade Occupation	
1. father	3
2. mother	3
3. son	1
4. daughter	0
II. Problem areas	
A. Getting to bed	3

Bedtime: Scoring	Importance
B. Staying in bed	5
C. Parental relationship	
1. Communication	4
2. Time spent together	4
3. Sex	3
III. Problem Background	
A. Getting to bed	
1. How long problem has been occuring	5
2. frequency of problem	5
3. Intensity	4
a. details of child's behaviors	
4. mother's behavioral response	4
5. father's behavioral response	4
6. mother's feelings about problem	4
7. father's feelings about problem	4
8. sleeping arrangements (Own room, etc.)	2
9. impact upon sister	1
B. Staying in bed	
1. how long problem been occuring	5
2. frequency of problem	5
3. intensity	
a. details of child's behaviors	4
4. mother's behavioral response	5
5. father's behavioral response	3

Bedtime: Scoring Importance

6. mother's feelings about problem 4

7. father's feelings about problem 4

8. impact upon baby sister 2

C. Child - general

1. developmental milestones (any lags?) 3

2. verbal/intellectual skills 2

3. peer relationships 2

4. relationship with mother

a. time together 4

b. enjoy each other 3

c. obeys mother 2

5. relationship with father

a. time together 4

b. enjoy each other 3

c. obeys father 2

6. child's relationship with sister

a. feelings 4

b. behaviors (any aggression or regression? 4

D. Parental relationship

1. mother's satisfaction with life

a. time to self 3

b. help with children

1. from husband 5

2. from others 3

Bedtime: Scoring Importance

c. time alone with husband 5

d. fun with husband 4

e. career aspirations 3

f. feelings about being at home with children 3

f. Amy and Josh planned? 2

g. feelings about marital relationship 4

2. father's satisfaction with life

a. involvement with family/ work 4

b. time to self 3

c. feelings about marital relationship 4

d. felings about children 3

3. Communication

a. amount parents talk in general 4

b. amount talk about child's problems 3

c. ability to compromise and resolve problems 3

d. amount share feelings with each other 3

e. amount of agreement in childrearing 2

4. Sex

a. impact of problem and mother's response (sleeping with child) on sexual relationship 5

b. frequency of sexual act now 3

1. prior to Amy's birth 3

Bedtime: Scoring Importance

c. duration of decreased frequency 3

d. reasons for decreased frequency

1. pain after last birth 4

e. enjoyment of sex

1. prior to Amy's birth

a. wife's enjoyment` 3

b. husband's enjoyment 3

2. since

a. wife's enjoyment 3

b. husband's enjoyment 3

f. wife's feelings about sexual relationship 5

g. husband`s feelings about sexual relationship 5

h. amount parents talk about this 4

i. mother's feelings about her sleeping with child 3

j. father's feelings about wife sleeping with child. 3

E. Why call now? 3

IV. Interventions

A. For child's behaviors

1. limit setting 5

a. education:

1. importance of limits 5

2. importance of consistency 5

Bedtime: Scoring	Importance
b. time out procedure	2
c. charting procedure	4
d. other limits (e.g., don't go in when he cries)	4
2. reponse to birth of new child	
a. education	
1. typical responses (regression, acting out)	3
2. children need a little more attention	3
b. suggestions	
1. extra time with parents	3
2. attention for being a "big boy"	3
B. For parental relationship	
1. Communication	
a. talk to husband	
1. child-rearing	3
2. her feelings and need for more help with children	4
3. need for more time together having fun	5
4. sexual situation	5

ASSESSMENT: Toilet Training protocol

Child: Danielle, age 4 3/4
Infant: Kitty, age 3 months
Mother: June, age 28
Father: Bud, age 28

Presenting problem

Danielle had been toilet trained successfully at around 2 1/2 years. About three months ago when her younger sibliing was born, she lost both bladder and bowel control.

Family history

Parents have been married for six years. They have few fights and their communication is good. They thought that they couldn't have children of their own (low sperm count), so they adopted Danielle when she was two weeks old. When she was almost four, they told Danielle that she was adopted ("We picked you specially because we loved you so much.") She seemed to accept that explanation. Since then they proved able to have a child (Kitty) who was born three months ago.

Mom and Dad have been fairly patient, but their impatience and frustration has them "at the end of their rope" due to the incontinence. They are starting to yell at Danielle a lot, and spank her at less provocation than before. No one in the family has had a history of enuresis.

Danielle has problems only while at home, not at daycare (which she enjoys) or at the home of the grandparents. At home she soils herself at least once a day and is wet almost every night. Her parents have recently been spending less time with her than before, because of the birth of her sister. Danielle treats her sister well.

Other

Daniele wants to be fed with a bottle or nurse at the breast like Kitty. She is not eating well.

Dad has been working overtime at the factory.

Mother has been in the hospital twice during the past year (appendix removal, pneumonia). At these times, the grandmother cared for the children. Danielle loves her

grandmother.

Danielle has three friends her age, two girls and one boy. There is no noncompliance or other problems. A medical examiniation proved completely negative.

Toilet Training: Scoring

		Importance
I. A.	Who is in family (presence or absence in home)	
	1. father	5
	2. mother	5
	3. daughter	5
	4. baby	5
B.	Ages	
	1. father	1
	2. mother	1
	3. daughter	5
	4. baby	5
C.	Names	
	1. father	1
	2. mother	1
	3. daughter	1
	4. baby	1
D.	Grade/Occupation	
	1. father	3
	2. mother	3
	3. daughter	4
II.	Problem areas	
A.	Loss of bladder and bowel control	5

Toilet Training: Scoring	Importance
B. Regressed behavior (drinking from bottle and wanting to nurse	5
C. Loss of appetite	5
III. Problem background	
A. Toileting problem	
1. ever been trained	5
a. bladder	5
b. bowel	5
3. when trained successfully	
a. bladder	5
b. bowel	5
3. Onset	
a. when	5
b. any changes at the time	
1. new baby	5
2. father working overtine	5
4. anyone in family have history of enuresis or encopresis	5
5. how often does problem occur	
a. enuresis	5
b. encopresis	5
6. does problem occur outside of home	5
7. Danielle's feelings about problem	5
8. Danielle's feelings about new sister	5

Toilet Training: Scoring	Importance
9. Mother's feelings about problem	5
10. father`s feelings about problem	5
11. mother's feelings about new baby	3
12. father's feelings about new baby	3
13. medical examination	5
14. mother's response to problem	5
15. father's response to problem	5
B. Regression	
1. onset	5
2. mother's feelings	5
3. father's feelings	5
4. mother's response	5
5. father's response	5
C. Loss of appetite	
1. how much does she eat	2
2. how much did she used to eat	2
3. mother's feelings	2
4. father's feelings	2
5. mother's response	2
6. father's response	2
D. Child- General	
1. milestones (any lags?)	5

Toilet Training: Scoring	Importance
2. verbal/intellectual	5
3. peer relationships	5
4. relationship with mother	
a. time together	5
b. enjoyment	5
c. closeness	5
5. relationship with father	
a. time together	5
b. enjoyment	5
c. closeness	5
6. general happiness	
a. before new sister	5
b. now	5
E. Family - general	
1. mother in hospital twice past year	5
2. Danielle's reaction to mother's absence	5
3. Who stayed with Danielle	5
4. relationship with that caretaker	5
IV. Intervention	
A. Toilet training	
1. reassurance: very common at such a time	5
2. talk to Danielle about	
a. her feelings about problem	5

Toilet Training: Scoring	Importance
b. her feelings about her new sister	5
c. how she can be such a big help as a big girl	5
3. parents spend more time with Danielle when possible	5
4. chart	
B. Regression	
1. reassure: very common at time like this	5
2. talk about	
a. Danielle being big girl	5
b. Danielle wanting to be baby like little sister sometimes	5
3. let Danielle act like a baby for a little while then say now lets be a big girl and help me	2
C. Eating	
1. reassure: She'll eat when hungry	2
2. be with Danielle during eating times when possible	2

ASSESSMENT: Sibling Rivalry protocol

Mother: Julie, age 32 (third of 5 children)
Father: John, age 31 (only child)
Son: David, age 7
Son: Mark, age 5
Son: Michael, age 2

Presenting problem

Mark, the middle child, needs something special to do, as his older brother is good at whatever he tries. Mark needs a special activity. He likes music, he always plays with musical toys, at friends' houses he will play the piano. Mom wonders if she should try music lessons.

Background

Mark and David fight frequently, both verbally with name calling, teasing etc, and physically, kicking, hitting, etc. For instance, this morning at breakfast, they started calling each other names (you dummy, etc.) and ended up grabbing each other's arms and hitting. Sometimes one will walk by and the other will kick him in the rear. They get along OK if there are other kids around. Their next door neighbors have two sons the same ages as Mark and David, and they usually play within their own age groups.

David and Michael get along well. Sometimes Mark teases him by taking away his toys, however, and they don't frequently play together.

David is good at everything. He is good in school and is a leader. He can ride a bike, and everything he tries he seems to be able to master. He is outgoing and friendly, and gets along well with peers and teachers.

Mark is withdrawn and very quiet around the family. If he gets upset or mad, he withdraws and sulks. He doesn't communicate verbally how he is feeling. He doesn't like to try new things. He is a follower. He goes along with whatever his brother or peers are doing. Mom is worried about

him getting into serious trouble when he is older because of this. For instance, he is supposed to stay on their block when he is outside, but yesterday, he went several blocks away with his friends, even though he knows better. When he gets reprimanded, he goes to his room and sulks and won't say anything to anyone.

He is capable of turning on the charm, especially when he is outside of the family. He becomes more animated when he is away from home. He was gone with a friend and his friend's family for about four days and he came back like a new person. The friend's parents said he was great, they had a lot of fun. As soon as he was home for awhile, he began to withdraw again. At school he gets along well with his peers, but he goofs off and doesn't finish his work. Mark hasn't said he wants music lessons, but Mom feels it would make him feel special.

Family relationships

The family does lots of things together. They go camping and on outings during the weekends. Often there are problems between Mark and David unless other kids are around. During the week Mom takes them to the library, shopping, etc. She has a garden and a busy schedule, so she doen't spend much time alone. Maybe once a week Mom and Dad go to a movie or dinner together.

Parental relationship and background

Dad was an only child so he thinks kids shouldn't fight. Mom is from a family of five, so she knows that kids do fight. She feels that she needs to keep peace between the boys to keep her husband from getting upset. She feels guilty for not being able to control the situation, especially when her husband is present. She usually deals with the fighting by voicing idle threats, such as "If you don't stop, you won't get any dessert" (but she usually doesn't hold to her threats). She admonishes them to keep their hands to themselves, to share their toys, and gives other vague commands. She occasionally spanks them if they do something very disruptive or if they break a safety rule, such as going out of the area in which they are allowed to travel.

However, when John is absent, she is more likely to leave them alone and ignore them. They usually quit after awhile. When she threatens them or spanks them, it may stop the problem momentarily, but it is not very effective. She ends up getting frustrated and yelling. John does the same when he is present. He also gets mad at Julie for not keeping things under control. They have a hard time reaching agreements many times. They have different backgrounds and attitudes, and can't seem to convince the other that their view is right. They can't seem to compromise.

Dad works outside the home. They are not troubled financially. They take a vacation at least once a year.

Sibling Rivalry: Scoring

	Importance
I. A. Who is in family (presence or absence in home)	
1. father	5
2. mother	5
3. son (Mark)	5
4. son (David)	5
5. son (Michael)	5
B. Names	
1. father	1
2. mother	1
3. son (Mark)	2
4. son (David)	2
5. son (Michael)	2
B. Ages	
1. father	1
2. mother	1
3. son (Mark)	5
4. son (David)	5
5. son (Michael)	5
C. Grade/Occupation	
1. father	2
2. mother	2
3. son (Mark)	4

Sibling Rivalry: Scoring	Importance
4. son (David)	4
5. son (Michael)	4
E. Length of marriage	3
F. Mother's family of origin constellation	4
G. Father's family of origin constellation	4
II. Problem	
A. Should Mark have music lessons	5
B. Fighting with brother	5
B. Parental relationship: disagreement about fighting	5
D. Being a follower	3
III. Problem background	
A. Child-general	
1. developmental milestones (any lags?)	4
2. verbal/intellectual skills	4
3. peer relationships	
a. number of	5
b. enjoyment of	5
4. relationship with mother	
a. time together	4
b. obedience	4
c. enjoyment	4
d. closeness	4

Sibling Rivalry: Scoring	Importance
5. relationship with father	
a. time together	4
b. obedience	4
c. enjoyment	4
d. closeness	4
6. relationship with David	
a. time together	5
b. closeness	5
6. relationship with Michael	
a. time together	5
b. closeness	5
8. School performance	
a. academic	5
b. behavior	5
9. differences home and away from home	
a. Mark's general happiness	
1. home	4
2. away	4
b. fighting	
1. home	4
2. away	4
B. Should Mark have music lessons	
1. why does caller feel would be a good idea	4
a. David good at everything	4

Sibling Rivalry: Scoring	Importance
b. Mark feels can't compete	4
c. Mark is withdrawn	4
2. what does Mark enjoy doing	4
3. does Mark want music lessons	4
C. Fighting	
1. how often	5
2. with whom	
a. brother	5
b. anyone else	5
3. how intense	
a. exact behavior	5
4. what starts fight	5
5. mother's feelings about fighting	4
6. father's feelings about fighting	4
7. mother's response (actions) to fighting	5
8. father's response (actions) to fighting	5
D. Parents' communication and relationship	
1. parents talk about situation	5
2. parents' ability to cooperate	5
3. mother's feelings about parental disagreement	4
4. father's feelings about parental disagreement	4
5. parents generally have	

Sibling Rivalry: Scoring	Importance
difficulty reaching agreement	4
E. Being a follower	
1. how often happen	4
2. how serious the rule breaking	4
3. mother's response	4
4. father's response	4
5. mother's concerns	3
6. father's concerns	3
IV. Interventions	
A. Music lessons	
1. ask Mark if he wants	5
B. Fighting	
1. information: some fighting normal, how they fight and how often is the issue	5
2. reassurance: doesn't sound too serious	4
3. ways to control	
a. idle threats encourage	5
b. time out	
1. for Mark	2
2. for David	2
c. Charting	
1. for Mark	3
2. for David	3
d. more time for Mark with parents, doing fun things	3

Sibling Rivalry: Scoring	Importance
e. information: importance of not comparing children	3
C. Parental relationship	
1. talk to each other	
a. share frustration	5
b. agree on seriousness or lack of seriousness of problem	5
c. information: importance of consistency across parents	5
D. Following	
1. reassurance	
a. not any reason to worry about later life	2
b. doing fine in handling situation	2

ASSESSMENT: Sex protocol

Mom: Late 20's (married 2 years before son's birth)
Dad: Late 20's
Child: Brent, age 5 1/2

Presenting problem

This caller (can be wife or husband) calls asking "What is the best time to tell your children about sex?" and "How do you do it?". The caller is somewhat anxious and uncomfortable, and sometimes has trouble answering questions ("ums" and "you knows"). The caller is defensive if asked about how s/he feels about sex ("Why do you want to know?").

Family situation

In this call, the presenting problem is legitimate, but was prompted by something else; the child's masturbation. The caller has seen the child masturbating two times in the last month. The child is not aware that he was seen. He was alone each time. One time was in the bathroom; the second time he was observed when the parent came into his bedroom (after Brent was put to bed) to check on him. The caller is wondering if this is normal behavior. The masturbation incidents have gotten the parent thinking about how they (the parents) deal with sex in general and s/he is wondering if the parents should be better in how they deal with these things. So, the assessor is really dealing with two issues, the masturbation, as well as the presented questions..

Other information

The child started school (1st grade) in the last month. The parent calling is ambivalent about acceptance of masturbation ("Well, I know its supposed to be normal, but he is so young.").

Brent knows about pregnancy (Dad plants seeds in Mom) but he does not know how the seed gets there.

He has not been asking any questions about sex recently. The parents are affectionate (hug, kiss each other in front of him and hug and kiss him).

Parents' relationship

The non-calling parent is not concerned about the masturbation, s/he thinks it is no big deal.The parents have a generally good marriage. They communicate well, but are uncomfortable taking to each other about sex. Their sexual relationship is satisfactory.

Parents' background

Parents of the caller didn't talk about sex or masturbation, avoiding the entire issue. The caller doesn's know about the spouse's upbringing in this area.

Other

Basically, this parent is trying to "do good" with his/her child, but is uncomfortable with this area.

Sex: Scoring

		Importance
I. A.	Who is in family (presence in/out of home)	
	1. father	5
	2. mother	5
	3. child	5
B.	Names	
	1. father	1
	2. mother	1
	3. child	2
B.	Ages	
	1. father	1
	2. mother	1
	3. child	5
B.	Grade/occupation	
	1. father	2
	2. mother	2
	3. child	5
E.	Length of marriage	3
II.	Problem areas	
A.	Time to tell about sex	5
B.	Masturbation	5
III.	Problem Background	

Sex: Scoring	Importance
A. Time to tell about sex	
1. has the child been asking	4
2. what is the child's knowledge about sex	5
3. what has child been told	5
4. father's feelings about sexual education	5
5. mother's feelings about sex education	4
6. spouses' amount of communication about this issue	4
7. parental relationship	
a. communication in general	4
b. is sex an issue	3
8. intensity of problem for caller	
a. how upset is caller	4
b. how upset is spouse	3
B. Masturbation	
1. how often been occurring	5
2. how long has this been occuring	5
3. where masturbating	
a. only in private	4
4. father's feelings about masturbation	5
5. mother's feelings about masturbation	4

Sex: Scoring	Importance
6. parents talk about situation	4
7. father's response to masturbation	5
8. mother's response to masturbation	4
9. what would caller want to teach child about masturbation	4
10. why call today	3
11. any changes in life over last months	5
IV. Child- General	
A. Developmental milestones (any lags?)	3
B. Verbal/intellectual skills	3
C. Peer relationships	4
D. Relationship with mother	
1. enjoy each other	3
2. Problems?	4
E. Relationship with father	
1. enjoy each other	4
2. Problems?	4
F. School related problems	4
V. Interventions	
A. For talking about sex	
1. Gear for age`	5
2. books	4
3. will ask when wants to	4

Sex: Scoring	Importance
know	
B. About masturbation	
1. can talk about	5
2. rehearse what to say	3
C. Communicate with wife	
1. Feelings	3
2. response	3
D. Reassurance	
1. Normal for age	5
2. ignoring is OK	4

APPENDIX F

Sensitivity to Children Scale

Sensitivity to Children Scale (STC)

Name:_____ Age: _____
Telephone No.:_____ Sex: (F or M): ____
Date: _____

Instructions:

A series of situations will be found on the following pages. You are to pretend or imagine you are the parent (mother or father) of the child described. All the children in the following situations are to be considered six years old.

Your task is to write down exactly how you would respond to the child in each of the situations, in a work, sentence or short paragraph. Write down you exact words and/or actions, but do not explain why you said or did what you described Again, write down your exact words or actions as if you were writing a script for a play or movie (e.g., do not write "I would reassure or comfort him." Instead, for example, write "I would smile at him and in a quiet voice say, "Don't worry, Billy, Daddy and I love you.".

If you have children, their names, sex and ages:

Name	Sex	Age

1. You and your husband (wife) are going out for the evening. As you are leaving, you both say "good night" to your son, Frank. He begins to cry and pleads with you both not to go out and leave him alone even though he doesn't appear sick and the babysitter is one he has previously gotten along well with.

2. Your daughter Barbara has just come home from school; silent, sad-faced, and dragging her feet. You can tell by her manner that something unpleasant has happened to her.

3. You walk into your bedroom and find your son Bernie putting your wallet (pocketbook) down with a $10.00 bill in his hand. It is clear from his actions (looking shocked at your arrival, putting his hand with the money behind his back) that you have caught him stealing.

4. After hearing some screaming in the family room, you go there and find your daughter Susan hitting her two year old baby sister.

5. When emptying the garbage, you find at its bottom the broken remains of a toy you had given to your daughter Eve two weeks ago. It is clear that she didn't want you to find out about its being broken.

6. Before going to bed at 10:00 p.m., you go into your son Bert's bedroom to see if he has the blanket over him and to tuck him in, if necessary. You find him awake and masturbating. He sees you looking at him and as you approach he stops and pulls the blanket up to his chin.

7. You have completed shopping in a local supermarket, and as you are checking out your son Lee says he wants a candy bar. It is close to dinner time, so you say "NO" to his request. He then lies down and begins screaming and kicking at you.

8. Your daughter Clare has come home from school full of anger. Her class had been scheduled to go to the zoo for weeks and she was very eager to go. However, it rained today and the trip had to be rescheduled. She angrily exclaims: "I hate that school. Just because it rained we couldn't go.

9. Upon returning home from school you son Joe excitedly tells you about how his friend Mark was punched into a rain-filled puddle by some older boys. Joe says that they were just walking home from school when all of a sudden three sixth graders ran up from behind and shoved Mark into the puddle and ran away laughing.