

The Incredible Years® Series: A Developmental Approach

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Chapter in book: *Family-Centered Prevention Programs for Children and Adolescents: Theory, Research, and Large-Scale Dissemination*, edited by Mark, J. VanRyzin, Karol Kumpfer, Gregory Fosco, and Mark T. Greenberg, 2016, pp. 42-67.

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Introduction

Rates of clinically significant behavioral and emotional problems are as high as 6-15% in 3-12 year old children (Egger & Angold, 2006; Sawyer, 2000). These numbers are even higher for children from economically-disadvantaged families (Webster-Stratton & Hammond, 1998). Young children with early-onset behavioral and emotional difficulties are at increased risk of developing severe adjustment difficulties, conduct disorders, school drop out, violence and substance abuse in adolescence and adulthood (Costello, Foley, & Angold, 2006; Egger & Angold, 2006). However, the good news is that research has consistently indicated that early intervention with evidence-based parent, teacher, and child programs can prevent and reduce the development of conduct problems, strengthen social and emotional competence and school readiness and, in turn, prevent later development of secondary risk factors such as school underachievement and deviant peer groups (Kazdin & Weisz, 2010; Snyder, 2001).

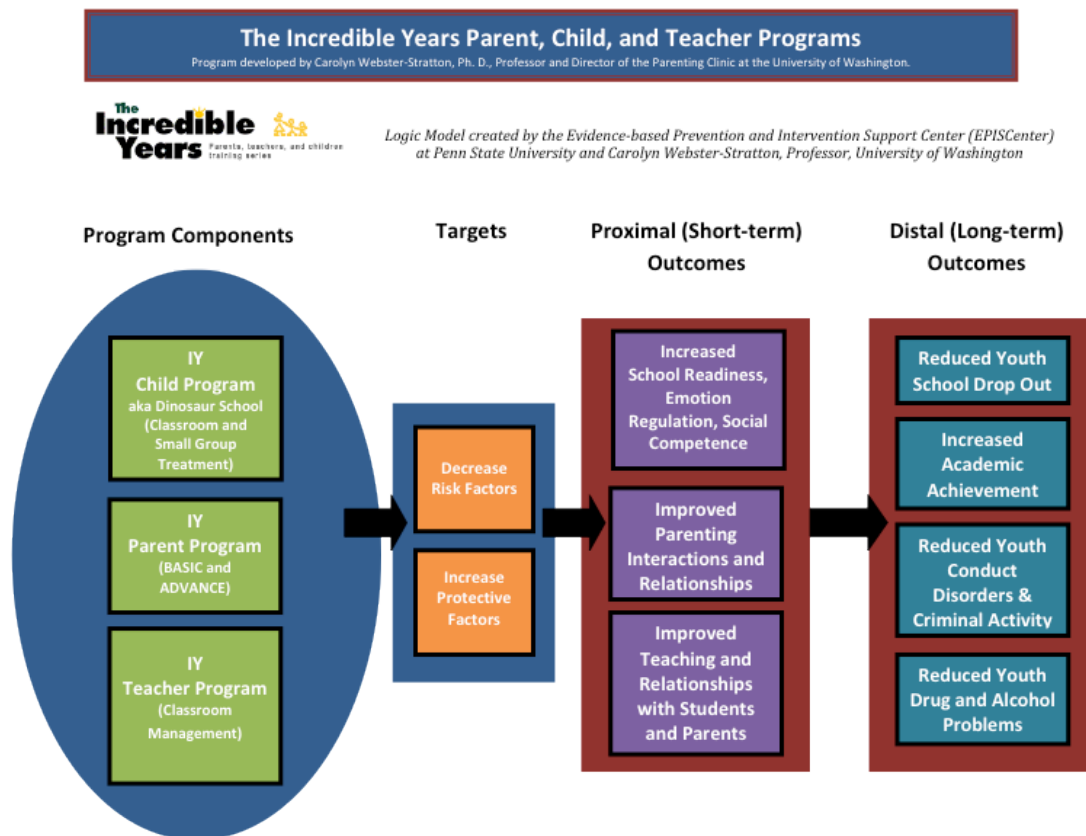
Multiple risk factors contribute to young children's behavioral and emotional problems including ineffective parenting (e.g., harsh discipline, low parent involvement in school, neglect and low monitoring)(Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict, parental drug abuse, mental illness, and criminal behavior) (Knutson, DeGarmo, Koepl, & Reid, 2005); child biological and developmental risk factors (e.g., attention deficit hyperactivity disorders (ADHD), learning disabilities, and language delays); school risk factors (e.g., poor classroom management, high levels of classroom aggression, large class sizes, and poor school-home communication); and peer and community risk factors (e.g., poverty and gangs) (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Effective interventions for preventing and reducing behavior problems ideally target multiple risk factors and are best offered as early as possible.

Need for Early Intervention

Extensive research over the past thirty years has consistently demonstrated the links between child, family, and school risk factors and the subsequent development of antisocial behaviors. Several prominent researchers (e.g., Dishion & Piehler, 2007; Dodge, 1993; Moffitt, 1993; G. Patterson, Reid, & Dishion, 1992; G. R. Patterson & Fisher, 2002) have helped coalesce this literature into strongly supported theories about the development of antisocial behaviors which in combination with developmental theory have had some obvious implications for interventions. First, early intervention timed to key child developmental periods is critical. Treatment-outcome studies suggest that interventions for conduct disorders (CD) are of limited effect when offered in adolescence, after delinquent and aggressive behaviors are entrenched, and secondary risk factors such as academic failure, school absence, substance abuse and the formation of deviant peer groups have developed (Dishion & Piehler, 2007; Offord & Bennet, 1994). Second, effective interventions need to target multiple risk factors across various settings. The increased treatment resistance in older CD probands results in part from delinquent behaviors becoming embedded in a broader array of reinforcement systems, including those at the family, school, peer group, neighborhood, and community levels (Lynam et al., 2000). Thirdly, significant advances in brain development research and in the conceptualization and practice of prevention science in mental health emphasize that interventions must start early, target multiple risk- and protective factors and be tied to theoretical and life-course models. Moreover, in a recent Cochrane review by Furlong and colleagues (Furlong et al.,

2010) showed that group-based parenting programs improve child behavior problems (whether measured independently or by parents) not only because they strengthen parenting skills but because they also improve parental mental health due to the support provided by the group. This suggests the added value of programs that reduce participant isolation and stigmatization and increase their support networks.

For these reasons, the Incredible Years® (IY) Series, a set of interlocking and comprehensive group training programs was designed to prevent and treat behavior problems when they first begin (infancy–toddlerhood through middle childhood) and to intervene in multiple areas and settings through parent, teacher, and child training. Early intervention across multiple contexts can counteract malleable risk factors and strengthen protective factors, thereby helping to prevent a developmental trajectory to increasingly aggressive and violent behaviors in later life. The model’s hypothesis is that improving protective factors such as responsive and positive parent-teacher-child interactions and relationships as well as group support will lead to improved school readiness, emotion regulation, and social competence in young children. These short term gains would, in turn, lead to increased academic achievement and reduced school drop-out, conduct disorders, and substance abuse problems in later life.



This chapter will focus on the underlying theoretical background for the three IY BASIC parent programs (toddler, preschool and school-age) which are considered “core” and a necessary component of the prevention model for young children. In addition it will discuss how the other IY adjunct parent, teacher, and child programs are added to address family risk factors and children’s developmental issues. Information regarding IY program content and delivery methods will be briefly described as well as research evidence, and

ways to promote successful delivery of the programs. More information regarding specific program objectives can be found on the web site <http://incredibleyears.com/about/incredible-years-series/objectives/>

Theoretical Background for Incredible Years Program Content & Methods

The main underlying theoretical background for all the parent, teacher, and child programs include the following:

- Cognitive social learning theory, and in particular Patterson’s “coercion hypothesis” of negative reinforcement developing and maintaining deviant behavior (G. Patterson et al., 1992)
- Bandura’s modeling and self-efficacy theories (Albert Bandura, 1986)
- Piaget’s developmental cognitive learning stages and interactive learning method (Piaget & Inhelder, 1962)
- Cognitive strategies for challenging angry, negative and depressive self-talk and increasing parent self-esteem and self-confidence (Beck, 1979; D’Zurilla & Nezu, 1982; Jacobson & Margolin, 1979)
- Attachment and relationship theories (Ainsworth, 1974; Bowlby, 1980)

Cognitive social learning theory, modeling, self-efficacy, attachment and relationship building, and child development theories underlie the delivery method for all the IY series. Video-based modeling is based on social learning and modeling theory (A. Bandura, 1977), which contends that observation of a model on video can support the learning of new skills. In the IY series, video-based modeling involves showing participants vignettes of parents or teachers representing different cultural backgrounds using social and emotional coaching, or positive discipline strategies, or of children managing conflict with appropriate solutions. Group leaders use the vignettes to engage participants in group discussion, collaborative learning and emotional support. Further, participants identify key “principles” from the vignettes, apply them to their personal goals by practicing what they have learned with their personal problem situation and then receive direct feedback on their performance from the group leader and group members. Previous research indicates that participants tend to implement interventions with greater integrity when they are coached and given feedback on their use of the intervention strategies (Reinke, Stormont, Webster-Stratton, Newcomer, & Herman, 2012; Stormont, Smith, & Lewis, 2007). After learning and practicing new strategies in the group, participants make decisions about how they will apply the ideas to address their personal goals in their homes or classrooms.

The group format has several advantages. First, it is more cost-effective than individual intervention and also addresses an important risk factor for children with behavior problems including the family’s isolation and stigmatization, teacher’s sense of frustration and blame, and children’s feelings of loneliness or peer rejection. Another benefit of the group format is that it helps reduce resistance to the intervention through motivational interviewing principles (Miller & Rollnick, 2002) and use of the collective group wisdom. Rather than receiving information solely from an expert, participants are given the opportunity to interact with each other. When participants express beliefs counter to effective practices, the group leader draws on others to express other viewpoints. Through this discourse, the group leader is able to elicit change talk from the participants themselves that makes it more likely they will follow through on intended changes. When group leaders position themselves in the “expert model” arguing for change, it is more likely to cement the attitudes of participants who are resistant to the intervention (see (Miller & Rollnick, 2002). On the other hand, video vignettes allow group leaders to elicit behavioral principles from the parents’ insights and serve as the stimulus for collaborative learning and practice exercises.

Group leaders always operate within a collaborative context which is designed to ensure that the intervention is sensitive to individual cultural differences and personal values. The program is "tailored" to each parent, teacher or child's individual needs and personal goals as well as to each child's personality, developmental ability and behavior problems. The collaborative therapy process is also provided in a text for group leaders, titled *Collaborating with Parents to Reduce Children's Behavior Problems: A Book for Therapists Using the Incredible Years Programs* (Webster-Stratton, 2012a).

Incredible Years® Core Parent Programs

The BASIC (core) parent training consists of 4 different curriculum designed to fit the developmental stage of the child: Baby Program (4 weeks to 9 months), Toddler Program (1- 3 years), Preschool Program (3-5 years) and School-Age Program (6-12 years). Each of these recently updated programs emphasize developmentally appropriate parenting skills and include age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. The programs run from 9-22 weeks, depending on the age of the child and the presenting issues of the parents and children in the group. The recommended program length and protocols for delivery is longer for older children and for higher risk families and children and can be found on the web site..

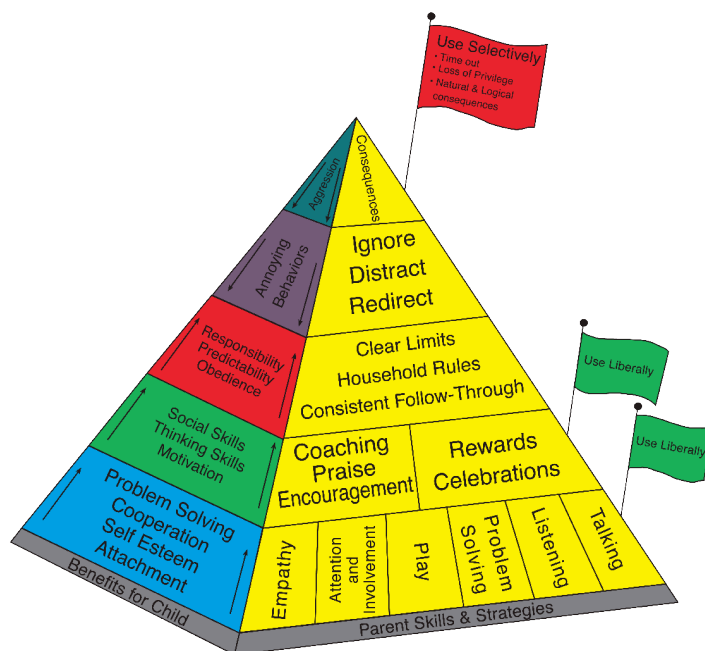
For each of these parent training programs, trained and, ideally, accredited IY group leaders/clinicians use DVD vignettes of modeled parenting skills (over 300 vignettes, each lasting approximately 1-3 minutes) which are shown to groups of 8-12 parents. The video vignettes demonstrate child development as well as parenting principles and serve as the stimulus for focused discussions, self-reflection, problem solving, practices, and collaborative learning. The programs are designed to help parents understand typical child developmental milestones and varying temperaments, child safety-proofing and monitoring, as well as age-appropriate parenting responses.

While participation in the group based IY training program is recommended because of the support and learning provided by other parents, there is also a *Home-based Coaching Model* for each parenting program. These home-based sessions can be offered to parents who cannot attend groups, or as make-up when parents miss a group session, or to supplement the group program for very high risk families.

Goals of each the programs are tailored specifically to the targeted age group and developmental stage of the child and include: (a) promoting parent competencies and strengthening families by increasing positive parenting, parent-child attachment, and self-confidence about parenting; (b) increasing parents' ability to use child-directed play interactions to coach children's social-emotional, academic, verbal, and persistence skills; (c) reducing critical and physically violent discipline and increasing positive discipline strategies such as ignoring and redirecting, logical consequences, time-out, and problem-solving; (d) increasing family support networks; and (e) strengthening home-school bonding and parents' involvement in school related activities and connections with teachers.

The Incredible Years Parenting Pyramid® serves as the architectural plan for delivering content and is used to describe the program content structure. It helps parents conceptualize effective parenting tools and how these tools will help them achieve their goals. The bottom of the pyramid depicts parenting tools that are used liberally, as they form the foundation for children's emotional, social and academic learning. The base of the pyramid includes tools such as positive parent attention, communication, and child-directed

play interactions designed to build secure and trusting relationships. Parents also learn how to use specific academic, persistence, social and emotional coaching tools to help children learn to self-regulate and manage their feelings, persist with learning despite obstacles, and develop friendships. One step further up the pyramid parents are taught behavior-specific praise, incentive programs, and celebrations for use when goals are achieved. Next parents discuss the use of predictable routines and household rules which scaffold children's exploratory behaviors and their drive for autonomy. The top half of the pyramid teaches parenting tools that are used more sparingly, to reduce specific targeted behaviors. These include proactive discipline tools such as ignoring of inappropriate behaviors, distraction and redirection. Finally, at the very top of the pyramid are more intrusive discipline tools such as Time Out to calm down for aggressive behaviors and logical consequences. After the top of the pyramid is reached, the last part of the training focuses on how parents can come back down the pyramid to the base of the pyramid. This refocuses parents on positive and proactive strategies for teaching children to problem solve, self-regulate, and manage conflict. At this point parents have all the necessary tools to navigate some of the uncomfortable, but inevitable, aspects of their interactions with their children. A basic premise of the model is twofold: first, a positive relationship foundation must precede clear and predictable discipline strategies. This sequence of delivery of content is critical to the program's success. Second, attention to positive behavior, feelings, and cognitions should occur far more frequently than attention to negative behaviors, feelings and cognitions. Tools from higher up on the pyramid only work when the positive foundation has been solidly constructed with secure scaffolding.



Parenting Pyramid®

Incredible Years® Adjuncts to Parent Programs

In addition to the core BASIC parenting programs there are also supplemental or adjunct parenting programs to be used in combination with BASIC for particular populations. The ADVANCE parenting program, offered after completion of the BASIC preschool or school-age programs, was designed for selective high-risk and indicated populations and focuses on parents' interpersonal risk factors such as anger and depression management, effective communication, ways to give and get support, problem-solving between adults, and ways to teach children problem solving skills. The content of both the BASIC and ADVANCE programs is also provided in the text that parents use for the preschool and school-age programs, titled *The Incredible Years: A Troubleshooting Guide for Parents* (Webster-Stratton, 2005; Webster-Stratton & Reid, 2006). A second optional adjunct training to the Preschool Program is the *School Readiness Program* for children ages 3–4 years that is designed to help parents support their children's preliteracy and interactive reading readiness skills. A third optional adjunct for the Toddler, Preschool, and Early School Age programs is the *Attentive Parenting Program* for children ages 2 to 8 years. This group prevention program is designed to teach parents social, emotional and persistence coaching, reading skills and how to promote their children's self-regulation skills and problem-solving skills. There are protocols for both the toddler age group and the early school age period. The *Attentive Parenting Program* is not designed for parents of children with behavior problems, although can be used for this population after the BASIC parenting program is completed and parents have learned the basic parenting tools. Finally, the most recent *Autism Program* is for parents of children on the autism spectrum or whose children have language delays. It can be used independently or in conjunction with the BASIC preschool program.

Incredible Years® Teacher Classroom Management Program

The Incredible Years® Teacher Classroom Management (IY-TCM) training program is a 6-day group-based program delivered monthly by accredited group leaders in small workshops (14-16 teachers) throughout the school year in order to provide teachers with ongoing support. It is also recommended that trained IY coaches support teachers between workshops by visiting their classrooms, helping refine behavior plans, and addressing teacher's goals. The goals of the teacher training program are the following: (a) improving teachers' classroom management skills, including proactive teaching approaches and effective discipline; (b) increasing teachers' use of academic, persistence, social, and emotional coaching with students; (c) strengthening teacher–student bonding; (d) increasing teachers' ability to teach social skills, anger management, and problem-solving skills in the classroom; (e) improving home–school collaboration, behavior planning and parent–teacher bonding and (f) building teachers' support networks. A complete and recently updated description of the content included in this curriculum is described in the book that teachers use for the course, titled *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence* (Webster-Stratton, 2012b). More information about the training and delivery of the IY teacher program can be found elsewhere (Reinke et al., 2012) (Webster-Stratton & Herman, 2010).

Incredible Years® Child Programs (Dinosaur Curricula)

There are two versions of the IY child program. In the universal prevention classroom version teachers deliver 60+ social-emotional lessons and small group activities twice a week, with separate lesson plans for preschool-second grade. The second version is a small group therapeutic treatment group where accredited IY group leaders work with

groups of 4–6 children in 2- hour weekly therapy sessions. The therapeutic version of the program can be offered in a mental health setting (often delivered at the same time as the BASIC parent program) or can be delivered as a pull-out program during the school day. Program content is delivered using a series of DVD programs (over 180 vignettes) that teach children feelings literacy, social skills, emotional self-regulation skills, importance of following school rules and problem solving. Large puppets are used to bring the material to life, and children are actively engaged in the material through role play, games, play, and activities. Organized to dovetail with the content of the parent training program, the program consists of seven main components: (1) Introduction and Rules; (2) Empathy and Emotion; (3) Problem-Solving; (4) Anger Control; (5) Friendship Skills; (6) Communication Skills; and (7) School Skills. More information about the child programs can be found in other reviews (Webster-Stratton & Reid, 2003, 2004).

Evidence Supporting the *Incredible Years* Parent Programs

Treatment and Indicated Populations: The efficacy¹ of the IY BASIC parent treatment program for children (ages 2–8 years) diagnosed with ODD/CD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer plus numerous replications by independent investigators . See review on web site library and research book for review of studies <http://incredibleyears.com/books/iy-training-series-book/> .

In the early studies, the BASIC program was shown to improve parental confidence, increase positive parenting strategies and reduce harsh and coercive discipline and child conduct problems compared to wait-list control groups. The results were consistent for toddler, preschool and school age versions of the programs. The first series of RCTs evaluated the most effective training methods of bringing about parent behavior change. The video-based parent group discussion training approach (BASIC) was compared with the one-on-one personalized “bug in the ear” approach and a control group indicating that the video-based discussion approach was as effective as the one-on-one parent-child training approach but far more cost-effective and had more sustained results at 1-year follow-up (Webster-Stratton, 1984b). In the next study treatment component analyses compared 3 training methods: group discussion alone without video led by a trained clinician, group discussion plus video with a trained clinician, self-administered video with no clinician, and a control group. Results indicated that the combination of group discussion, a trained clinician, and video modeling produced the most effective and lasting results (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). Next the self-administered video program was compared with and without clinician consultation. There were few outcome differences, except that parent satisfaction was higher for the consultation condition (Webster-Stratton, 1992). Subsequently a study was conducted to determine the added benefits of combining the ADVANCE program (focused on interpersonal parent problems such as depression and anger management) with the BASIC program (Webster-Stratton, 1994). Results indicated that the combined program had greater improvements in terms of parents’ marital interactions and children’s prosocial solution generation in comparison to the BASIC only treatment condition families. As a result the combined BASIC plus ADVANCE programs became the core treatment for parents of children diagnosed with ODD and /or ADHD and has been used for the treatment studies in the last two decades.

Other investigators have replicated the BASIC program’s results with treatment

populations in mental health clinics, or doctor's offices with families of children diagnosed with conduct problems or high levels of behavior problems (Drugli & Larsson, 2006; Gardner, Burton, & Klimes, 2006; Lavigne et al., 2008; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014; Scott, Knapp, Henderson, & Maughan, 2001; Spaccarelli, Cotler, & Penman, 1992; Taylor, Schmidt, Pepler, & Hodgins, 1998). A recent meta-analytic review examined the IY parent training programs regarding disruptive and prosocial behavior in 50 studies where the IY intervention group was compared with control or a comparison group. Results were presented for treatment populations as well as indicated and selective prevention populations. Findings reported the program to be successful in improving child behavior in a diverse range of families, especially for children with the most severe problems and the program was considered "well-established" (Menting, Orobio de Castro, & Matthys, 2013).

Several studies have also shown that IY treatment effects are durable 1-3 years post treatment (Webster-Stratton, 1990). Two long-term followup studies evaluated families whose children were diagnosed with conduct problems and had received treatment with the IY parent program 8- to 12-years earlier. One study indicated that 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). A recent study by an independent investigator reported that parents in the IY BASIC parent condition expressed greater emotional warmth and supervised their adolescents more closely, than parents in the control condition who had received individualized "typical" psychotherapy offered at that time. Moreover, their children's reading ability was substantially improved in a standardized assessment (Scott, Briskman, & O'Connor, 2014).

Prevention Populations: Additionally, 4 RCTs have been conducted by the developer using the prevention version of the BASIC program with multiethnic, socioeconomically disadvantaged families in schools, (Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001a). Results showed that children whose mothers received the BASIC program showed fewer externalizing problems, better emotion regulation, and stronger parent-child bonding than control children. Mothers in the parent intervention group also showed more supportive and less coercive parenting than control mothers (Reid, Webster-Stratton, & Hammond, 2007).

At least 6 RCTs by independent investigators with high risk prevention populations have found that the BASIC parenting program increases parents' use of positive and responsive attention with their children (praise, coaching, descriptive commenting) and positive discipline strategies, and reduces harsh, critical, and coercive discipline strategies (see review (Webster-Stratton & Reid, 2010). These replications were "effectiveness" trials in applied mental health settings, schools and doctor's clinical practices, not a university research clinic, and the IY group leaders were existing staff (nurses, social workers and psychologists) at the centers or doctor's offices (Perrin et al., 2014). The program has also been found to be effective with diverse populations including those representing Latino, Asian, African American, and Caucasian background in the United States (Reid et al., 2001), and in other countries such as the United Kingdom, Ireland, Norway, Sweden, Holland, New Zealand, Wales, and Russia (Gardner et al., 2006; Hutchings et al., 2007; Larsson et al., 2009; Raaijmakers et al., 2008; Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Scott et al., 2010). These findings illustrate the transportability of the BASIC parenting program to other cultures and countries.

Evidence Supporting the Incredible Years Child Programs as an Adjunct to IY Parent Programs

Treatment: Three RCTs have evaluated the effectiveness of combining the small-group child-training (CT) program to parent training (PT) for reducing conduct problems and promoting social and emotional competence in children diagnosed with ODD/CD (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Hammond, 2004). Results indicated that children who received the CT only condition showed enhanced improvements in problem solving, and conflict management skills with peers compared to those in the PT only condition. On measures of parent and child behavior at home, the PT only condition resulted in more positive parent-child behavioral interactions in comparison to interactions in the CT only condition. One-year follow-up assessments indicated that all the changes noted immediately post-treatment were maintained over time. Moreover, child conduct problems at home had decreased over time. Analyses of the clinical significance of the results suggested that the combined CT + PT condition produced the most sustained improvements in child behavior at 1-year follow-up. For this reason the CT program was combined with the PT program in a recent study for children diagnosed with ADHD. Results replicated the earlier studies with children with ODD (Webster-Stratton, Reid, & Beauchaine, 2011). There has only been one RCT by an independent investigator of the CT small group program (Drugli & Larsson, 2006).

Prevention: One RCT has evaluated the classroom prevention version of the child program with Head Start families and primary grade classrooms in schools addressing economically disadvantaged populations. Matched schools were randomly assigned to intervention or control conditions. In the intervention classrooms teachers offered the curriculum in biweekly sessions throughout the year. Results from multi-level models of reports and observations of 153 teachers and 1,768 students indicated that teachers used more positive management strategies and their students showed significant improvements in school readiness skills, emotional self-regulation and social skills, and reductions in behavior problems in the classroom. Intervention teachers showed more positive involvement with parents than control teachers. Satisfaction with the program was high regardless of the grade levels (Webster-Stratton, Reid, & Stoolmiller, 2008). A subsample of parents of indicated children (due to high levels of behavior problems by teacher or parent report) were selected and randomly offered either the combined parent program plus classroom intervention, or classroom only intervention, or control group. Mothers in the combined condition reported their children had fewer behavior problems and more emotional regulation than parents of children in classroom only condition or control condition. Mothers in the combined condition had stronger mother-child bonding and were more supportive and less critical than classroom only or control conditions. Teachers reported mothers in the combined condition were significantly more involved in school and their children had fewer behavior problems. This study indicates the added value of combining a social and emotional curriculum for students in the classroom with the IY parent program in schools (Reid et al., 2007).

Evidence Supporting Incredible Years Teacher Classroom Management (IY-TCM) Program as an Adjunct to IY Parent Programs

The IY-TCM program has been evaluated in one treatment (Webster-Stratton et al., 2004) and two prevention RCTs (Webster-Stratton et al., 2001a; Webster-Stratton et al., 2008) and five RCTs by independent investigators (see review (Webster-Stratton, 2012c). Research findings have shown that teachers who participated in the training used more proactive classroom management strategies, praised their students more, used fewer coercive or critical discipline strategies, and placed more focus on helping students to

problem solve. Intervention classrooms were rated as having a more positive classroom atmosphere, increases in child social competence and school readiness skills, and lower levels of aggressive behavior. In a study where BASIC parent alone treatment condition was compared with a treatment condition that combined BASIC with the IY-TCM teacher training program and with the combination of BASIC plus IY-TCM plus CT programs the results indicated that combining IY-TCM and/or CT programs with BASIC parent training resulted in enhanced improvements in classroom behaviors as well as more positive parent involvement in their child's education. A recent study has replicated the benefits of the IY-TCM program alone for enhancing parent involvement in their children's education (Reinke et al., 2014).

Factors Affecting Intervention Outcomes

In addition to studying the specific training methods (group support vs self-administered video vs combined video plus group support) and the benefits of adding adjunct components to the IY Basic Parenting Series programs (advance parenting, teacher and child training), over the past 30 years a number of studies have been conducted to determine mediator, moderators and predictors of outcomes. For example, parental and familial factors such as life stress, depression, marital adjustment, socioeconomic status, parental age, ethnicity and history of substance abuse (Beauchaine, Webster-Stratton, & Reid, 2005; Hartman, Stage, & Webster-Stratton, 2003; Reid et al., 2001; Webster-Stratton & Hammond, 1990), father involvement in treatment (Webster-Stratton, 1984a) and intergenerational family psychiatric history of antisocial behavior (Presnall, Webster-Stratton, & Constantino, in press) have been analyzed in regard to treatment response. Additionally, child risk factors such as age, gender, psychiatric comorbidity, degree of externalizing problems, and comorbidity with attentional factors (Hartman et al., 2003) (Webster-Stratton, 1996; Webster-Stratton, Reid, & Hammond, 2001b) and anxiety/depression (Beauchaine et al., 2005) as well as physiological measures of cardiac activity and reactivity (Beauchaine et al., 2013) were also analyzed. In general results indicated the beneficial effectiveness of IY parent programs irrespective of family variables such as depression, stress level, socio-economic status, and family psychiatric history. Counter to expectation, one study showed better long term child outcomes with younger mothers and those with a history of parental substance abuse (Beauchaine et al., 2005). Moreover, the IY programs were equally effective regardless of child gender, age or comorbidity with attentional problems (Hartman et al., 2003) or anxious depression scores (Beauchaine et al., 2005). However, critical, harsh and ineffective parenting both predicted and mediated outcome at 1-year follow-up (Beauchaine et al., 2005) and long-term follow-up (Webster-Stratton et al., 2010). These findings suggest that specific parenting goals be achieved before the parent program is discontinued, or that parents who still have high levels of coercive parenting (despite improvements from baseline) be selected for continued treatment with the advance parent program until therapeutic effectiveness has been achieved.

Implementation with fidelity

An important aspect of a program's efficacy is fidelity in implementation. Indeed, if the program is not rigorously followed (for example, if session components are dispensed with, program dosage reduced, necessary resources are not available, or group leaders not trained or supported with accredited mentors), then the absence of effects may be attributed not to the inefficacy of the program but to a lack of fidelity in its implementation (Hutchings et al. 2008). Recent research with the *Incredible Years* BASIC parenting program shows that implementation with a high degree of fidelity not only preserves the anticipated

behavior change mechanisms but is predictive of behavioral and relationship changes in parents, which, in turn, are predictive of social and emotional changes in the child as a result of the program (Eames et al., 2010).

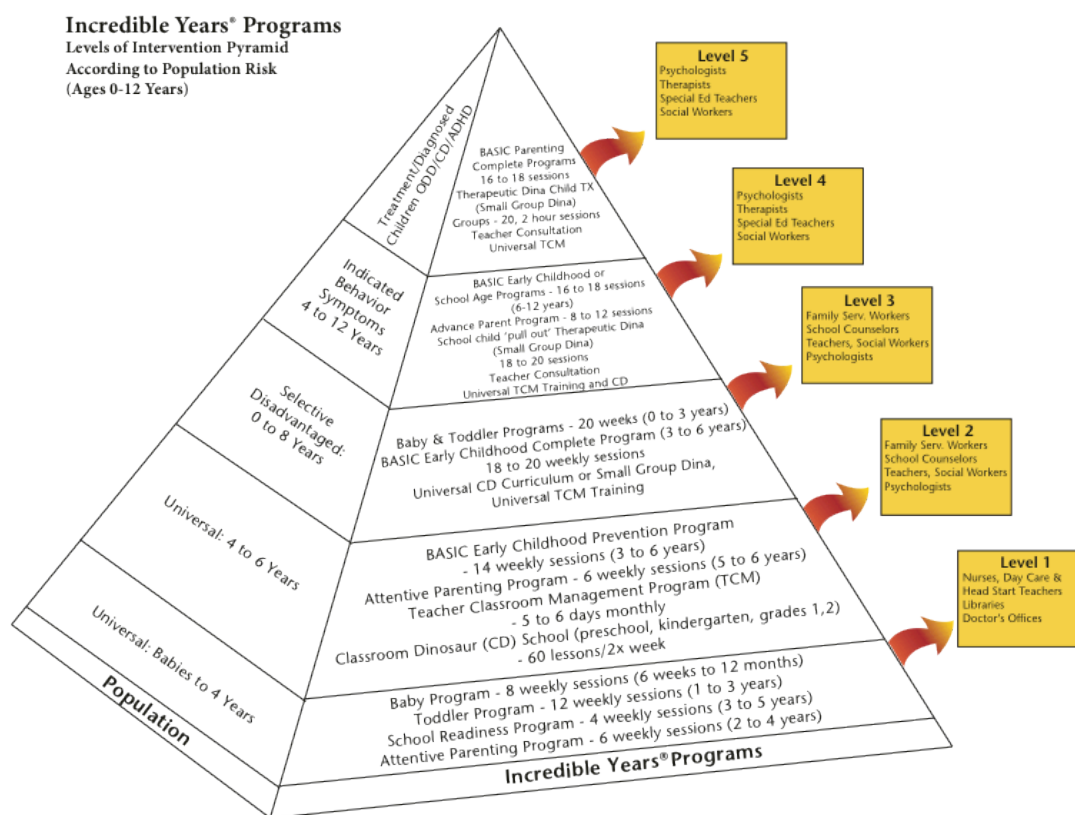
One important aspect that facilitates the application of a program with fidelity is the standardization of program content, structure, processes, methods and materials. In *Incredible Years*, all components relating to the implementation of the program content are described in detail in DVDs and manuals, which also lay out the basic theoretical and empirical elements of each part of the program. For Weisz (Weisz, 2004), one of the main advantages of the *Incredible Years* programs, from the point of view of clinical practice, is precisely the program's accessibility for clinical use, along with its appealing nature and low abandonment rates.

In the context of implementation with fidelity, the training and supervision of group leaders warrants great attention (Webster-Stratton, 2004). First, carefully selected and motivated group leaders receive 3 days of training by accredited mentors before leading their first group of parents or teachers. Then it is highly recommended they continue with ongoing consultation with IY coaches and/or mentors as they proceed through their first group. They are encouraged to start videotaping their sessions right away and to review these videos with their co-leader using the group leader checklist and peer review forms (Webster-Stratton, 2004). It is also recommended that they send these videos for outside coaching and consultation by an accredited IY coach or mentor as soon as possible. Group leaders find this video review immensely helpful and supportive.

The process of group leader accreditation is demanding, involving the leadership of at least two complete groups, video consultation, and a positive final video group assessment by an accredited mentor or trainer as well as satisfactory completion of group leader group session protocols and weekly participant evaluations. This process ensures that leaders are delivering the program with fidelity, which includes both content delivery (required number of sessions, vignettes, role plays, brainstorming) and therapeutic skills. The whole process of coaching, consultation, and accreditation of new group leaders is carried out by a network of national and international accredited IY mentors and trainers. A recent RCT has shown that providing group leaders with ongoing consultation and coaching following the 3-day workshop leads to increased group facilitator proficiency, program adherence and delivery fidelity (Webster-Stratton, Reid, & Marsenich, 2014).

Planning and Implementation of IY Programs According to Risk Level of Population

The BASIC parent program (baby, toddler, preschool or school-age version) is considered a mandatory or a "core" component of the prevention intervention training series. The ADVANCE program is offered in addition to the BASIC program for selective populations such as families characterized as depressed or with considerable marital discord, child-welfare referred families, or families living in shelters. For indicated children with behavior problems that are pervasive (i.e., apparent across settings both at home and at school) it is recommended that the child dinosaur training program and/or teacher training program be offered in conjunction with the parent training program to assure changes at school or day care. For indicated children whose parents cannot participate in the BASIC program due to their own psychological problems, delivery of both the child and teacher program is optimal.



Again the pyramid is used to depict the levels of intervention according to risk level of populations. As seen in this figure, **Levels 1 and 2** are the foundation of the pyramid and recommend a series of programs that could be offered *universally* to all parents of young children (0-6 years). These programs could be offered in pediatrician's offices, Head Start programs, day care centers, preschools and elementary schools. The group format is a cost efficient way of disseminating information to large numbers of people as a strategy to optimize positive parent-child interactions and to strengthen children's social and emotional competence and school readiness so that they are ready to start the next phase of their education.

Once children are in day care or preschool, providing universal supports for all children at this young age includes enhancing the capacity of day care, preschool, and Head Start teachers to provide structured, warm, and predictable environments at school. Thus, level 2 also involves training all early childhood teachers in effective classroom management strategies using the IY-TCM Program. After this training is completed and teachers also have the opportunity to receive training to deliver the classroom child dinosaur curriculum as a universal social skills intervention. This includes three different sets of lesson plans for preschool, kindergarten and grades 1 and 2. Ideally children receive this curriculum for three subsequent years, resulting in a strong emotional and social foundation by the time they are seven years old. This social and emotional competence is theorized to contribute to higher academic competence as children progress through school.

Level 3 is targeted at "*selective*" or *high risk populations*. These are populations that

are socio-economically disadvantaged and highly stressed because of increased risk factors such as parental unemployment, low education, housing difficulties, single parenthood, poor nutrition, maternal depression, drug or alcohol addiction, child deprivation, new immigrant status, or lack of academic preparedness for school. These economically disadvantaged parents would benefit from the complete baby, toddler, and early childhood parent program because of the support provided in the groups, the hope for change shown to them by group leaders, as well as their experiential learning that despite economic obstacles they can provide the best early years of emotional, social and cognitive parenting possible for their children. In addition, the teachers and care providers of these children could receive the IY-TCM program so that they are skilled at managing classroom behaviors problems, which are exhibited at higher rates in this population. Lastly, 3-8 year old children in these families would benefit from the classroom Dina Social and Emotional Skills Curriculum at least twice a week year round. This investment in building the social and emotional abilities in the first eight years of life for these vulnerable children can help to break the intergenerational transmission of disadvantage.

Level 4 on the pyramid is targeted at “*indicated populations*”, where children or parents are already showing symptoms of mental health problems. For example, parents referred to child protective services because of abuse or neglect, foster parents caring for children who have been neglected and removed from their homes, or children who are highly aggressive but not yet diagnosed as having ODD or CD. As can be seen on the pyramid, this level of intervention is offered to fewer people and offers a longer and more intensive parenting program by a higher level of trained professionals. These parents or caregivers would complete the entire age appropriate BASIC parenting program followed by the ADVANCE program.

The teachers of these children should receive the IY-TCM program and offer the classroom Dina Classroom Social, Emotional and Problem Solving Skills curriculum. In addition to this Dina classroom curriculum, children with symptoms of externalizing or internalizing problems or ADHD are targeted to be pulled out of class twice a week for the small group therapeutic Dinosaur program delivered by school psychologists or counselors or specially trained social workers or special education teachers. These children will meet in small groups (4-6 children) to get extra coaching and practice with social skills, emotional regulation, persistence coaching and literacy, and problem solving. This will reinforce the classroom learning of this program and will send these children back to a classroom where peers understand how to respond more positively to their special needs. In other words the whole classroom community has learned solutions to how to respond to a peer who may be aggressive or one who is sad, withdrawn or lonely.

Level 5 is the most comprehensive intervention, addressing multiple risk factors and is usually offered in mental health clinics by therapists with graduate level education in psychology, social work, or counseling. One of the goals of each of the prior levels is to maximize resources and minimize the number of children who will need these time and more cost intensive interventions at level 5. At a minimum the parents will receive the entire BASIC and ADVANCE curriculum for 24-28 weeks while the children attend 2-hour weekly therapeutic small group child Dina groups at the same time. Therapists dovetail these two curricula and keep parents and teachers fully informed of the skills children are learning in their child groups so that they can reinforce these at home or in the classroom. Additionally, if parents need individual coaching in parent-child interactions this can be provided in the clinic setting or in supplemental home visits using the home coaching protocols. Child and parent therapists work with parents to develop behavior problem plans and consult with teachers in partnerships to coordinate their plans, goals and helpful strategies. Successful interventions at this level are marked by an integrated team approach

with clear communication among all the providers and adult caregivers in the various settings where these children spend their time. Ideally mental health agencies would embody these services within schools which allows for less stigmatization for parents, greater coordination with teachers regarding behavior plans and more frequently pull out groups for children.

Conclusion

Future directions for research on IY programs should include evaluating ways to promote the sustainability of results such as by targeting parents whose baseline or post intervention parenting practices are particularly harsh or ineffective with additional resources such as offering a greater number of sessions, additional program adjuncts such as IY Advance Program, or IY Child Program and ongoing booster sessions. Similarly research concerning matching children to appropriate treatment combinations is needed. For example children could be assigned to treatment program conditions according to their particular comorbidity combinations. Our research suggests that children with ODD are comorbid for other diagnoses such as ADHD, depression or anxiety, language delays and Autism. Spectrum Disorder. Our initial findings suggest that children scoring high on Attention Problems or with ADHD will fare better when IY-TCM or CT components are added to the PT program. Further research is needed for identification of children for whom the current interventions are inadequate. Finally our newest IY baby program, Attentive Parenting program and Autism program are in need of RCTs to determine their effectiveness.

At a time when the efficient management of human and economic resources is crucial, the availability of evidence-based programs to parents and teachers should form part of the public health mission. While the IY programs have been shown in dozens of studies to be transportable and effective across different contexts worldwide, unfortunately, barriers to fidelity delivery impede the possibility for successful outcomes for parents, teachers and children. The lack of sufficient funding has led to IY programs being delivered by group leaders without adequate training, sufficient support, coaching and consultation, and without agency monitoring or assessment of outcomes. Frequently the programs have been sliced and diced and components dropped in order to offer the program in a dosage that can be funded. Few agencies support their group leaders to become accredited, and the program is often not well established enough to withstand staffing changes in an agency. Thus, the initial investment that an agency may make to purchase the program and train staff is often lost over time. If we think of disseminating evidence-based programs like constructing a house, it is as if the contractors hired electricians and plumbers who were not certified, disregarded the architectural plan and used poor quality, cheaper materials. Under these conditions, the building will not be structurally sound. Just like building a stable house, it is important the foundation and basic structure for delivering evidence-based programs be strong. This will include picking the right evidence-based program for the level of risk of the population and developmental status of the children and adequately training, supporting and coaching group leaders so they become accredited and providing quality control. In addition, providing adequate scaffolding through the use of trained and accredited coaches, mentors and administrators who can champion quality delivery will make all the difference. With a supportive infrastructure surrounding the program, initial investments will pay off in terms of strong family outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

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