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## EARLY INTERVENTION WITH VIDEOTAPE MODELING: PROGRAMS FOR FAMILIES OF CHILDREN WITH OPPOSITIONAL DEFIANT DISORDER OR CONDUCT DISORDER

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### OVERALL GOALS

The ultimate purpose of the Parenting Clinic's program of research is to develop, evaluate, and improve cost-effective, widely applicable, and theory-based early intervention programs of treatment for families with young children who suffer from oppositional-defiant disorder (ODD) or conduct disorder (CD). Children with these disorders typically exhibit a broad range of antisocial behaviors (i.e., lying, cheating, stealing, fighting, oppositional behaviors, and noncompliance to parental requests) at higher than normal rates. Our interest in such children was stimulated by research showing the high prevalence rates—rates that are increasing—for these conditions (4–10%); and, even more important, by research indicating that these aggressive children are at increased risk for being rejected by their peers (Coie, 1990) and abused by their parents (Reid, Taplin, & Loeber, 1981), as well as for school dropout, alcoholism, drug abuse, depression, juvenile delinquency, adult crime, antisocial personality, marital disruption,

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interpersonal problems, and other diagnosable psychiatric disorders (Kazdin, 1985; Loeber, 1991). Conduct disorders are one of the most costly of mental disorders to society because such a large proportion of antisocial children remains involved with mental health agencies or criminal justice systems throughout the course of their lives.

Developmental theorists have suggested that there may be two developmental pathways related to conduct disorder: the early starter versus the late starter models (Kazdin, 1985; Loeber, 1991; Patterson, DeBaryshe, & Ramsey, 1989). The hypothesized early-starter pathway begins formally with the emergence of ODD in early preschool years, progresses to aggressive and nonaggressive (e.g., lying, stealing) symptoms in middle childhood, and then develops into the most serious symptoms by adolescence, including interpersonal violence and property crimes (Lahey, Loeber, Quay, Frick, & Grimm, 1992). In contrast, the late starter pathway begins with a history of normal social and behavioral development during the preschool and early school years and progresses to symptoms of CD during adolescence. The prognosis for late starter adolescents appears to be more favorable than for adolescents who have a history of CD beginning in their preschool years; adolescents who first evidenced ODD symptoms in the preschool years followed by an early onset of CD are most likely to be chronically antisocial. These early-starter CD children also account for a disproportionate share of delinquent acts in adolescence. Thus, ODD is a sensitive predictor of CD; indeed, the primary developmental pathway for serious conduct disorders in adolescence and adulthood appears to be established during the preschool period (Campbell & Ewing, 1990; Loeber, 1991).

The preceding model showing the progression from ODD to CD suggests that, perhaps, the most strategic point for intervention in the child's development is the preschool and early elementary school years (i.e., ages 4 to 7 years). Our decision to focus our interventions on this age period was based on several considerations. First, there is evidence that ODD and CD children are clearly identifiable at this age. Our prior studies have revealed that even children as young as 4 years of age have already been expelled from two or more preschools and have experienced considerable peer and teacher rejection. Second, there is evidence that the younger the child at the time of intervention, the more positive the child's behavioral adjustment will be at home and at school (Strain, Steele, Ellis, & Timm, 1982). Third, the move to school—from preschool through the first years of elementary school—is a major transition and a period of great stress for many children and their parents. The child's early success or failure in adapting to school sets the stage not only for the child's future behavior at school and relationships with teachers and peers but also for the parents' future attitudes toward their child's schools and their own relationships with teachers and administrators. It is our belief that early intervention, if

it occurs strategically during the high-risk child's first major transition point, can counteract those risk factors and reinforce protective factors, thereby helping to prevent a developmental trajectory from early-onset conduct problems (i.e., young children with high rates of symptoms of ODD or CD) to increasingly aggressive and violent behaviors, negative reputations, peer rejection, low self-esteem, conduct disorders, and spiraling academic failure.

## TREATMENT PLAN

### Parent Skills Training Interventions

#### *Rationale for Parent Training*

One of the major intervention strategies for reducing child ODD and CD involves parent training. This approach uses a model in which ineffective parenting skills are the most important risk factor and intervening variable in the development and maintenance of conduct problems. We have been strongly influenced by G. R. Patterson's (1982, 1986) seminal work and theoretical formulations concerning the development of conduct disorder and problem behaviors. His social learning, interactional-based model emphasizes the importance of the family socialization processes. Patterson developed the *coercion hypothesis*, which postulates that children learn to get their own way and escape (or avoid) parental criticism by escalating their negative behaviors; this, in turn, leads to increasingly aversive parent interactions. As this coercive training in a family continues over time, the rate and intensity of aggressive behaviors, on the part of parents and children, increase. Moreover, as the child observes increasingly frequent parental anger and negative discipline, the child is provided with additional modeling (observational learning) of aggression (Patterson, 1982). The pioneering research of Patterson and others has found that parents of children with conduct disorders exhibit fewer positive behaviors, use more violent disciplinary techniques, are more critical, more permissive, less likely to monitor their children's behaviors and more likely to reinforce inappropriate behaviors while ignoring, or even punishing, prosocial behaviors (Patterson, 1982). Accordingly, we felt that if we could intervene with parent training, while these children were still very young and their families' negative styles of interaction still malleable, we could improve the poor long-term prognoses for these children and their families.

#### *Videotape Modeling Methods*

We were particularly interested in determining which methods of training parents were most effective, that is, cost-effective, widely appli-

cable, and sustaining. Cost effectiveness is vital because conduct disorders are increasingly widespread, creating a need for service that far exceeds available personnel and resources. For instance, data suggested that less than 10% of children who needed mental health services actually received them (Hobbs, 1982). Most of the early parent training programs relied largely on verbal methods, such as didactic lectures, brochures, and group discussions. Although these methods are cost effective, they have been shown to be ineffective for inducing behavioral changes in parents (Chilman, 1973). In addition, such methods are not optimal for parents whose literacy and educational levels, or general intellectual level is deficient. On the other hand, performance training methods, such as live modeling, role rehearsal, and individual video feedback, had proven effective in producing behavioral changes in parents and children (O'Dell, 1985); however, implementation was time consuming and costly, making them impractical in the face of increasing demand. Videotape modeling, on the other hand, was one method that appeared to be practical and cost effective.

In accordance with Bandura's (1977) modeling theory of learning, we hypothesized that parents could develop their parenting skills by watching (and modeling) videotape examples of parents interacting with their children in ways that promoted prosocial behaviors and decreased inappropriate behaviors. We theorized that videotape would provide a more flexible method of training than didactic instruction or role playing—that is, we could portray a wide variety of models and situations. We hypothesized that this flexible modeling approach would result in better generalization of the training content and, therefore, in better long-term maintenance. Furthermore, it would be a better method of learning for less verbally sophisticated parents. Finally, such a method, if proven effective, would have the advantage not only of low individual training cost when used in groups but also of possible mass dissemination. Thus, in 1979, we initiated our program of research to develop and evaluate videotape modeling parent intervention programs for families of young children with ODD and CD. We were interested both in evaluating the program's efficacy and in testing a theory of change processes. (See Table 1 for an outline of the videotape interventions tested.)

#### *Content and Process of the BASIC Parent Training Videotape Modeling Programs*

In 1980, we developed an interactive, videotape-based parent intervention program (BASIC) for parents of children aged 3 to 8 years. Heavily guided by the modeling literature, the BASIC program attempted to promote modeling effects for parents by creating positive feelings about the videotape models. For example, the videotapes show parents of differing ages, cultures, socioeconomic backgrounds, and temperaments, so that par-

**TABLE 1**  
**Overview of Videotape Interventions**

Interventions	Skills targeted	Person trained	Setting targeted
Parenting skills training (BASIC)	<ul style="list-style-type: none"> <li>▪ Parenting skills</li> <li>▪ Play, involvement</li> <li>▪ Praise, rewards</li> <li>▪ Limit setting</li> <li>▪ Discipline</li> </ul>	Parent	Home
Interpersonal skills training (ADVANCE)	<ul style="list-style-type: none"> <li>Interpersonal skills</li> <li>▪ Problem solving</li> <li>▪ Anger management</li> <li>▪ Communication</li> <li>▪ Depression control</li> <li>▪ Giving and receiving support</li> </ul>	Parent	Home, work, community
Academic skills training (PARTNERS 1)	<ul style="list-style-type: none"> <li>Academic skills</li> <li>▪ Academic stimulation</li> <li>▪ Learning routine after school</li> <li>▪ Homework support</li> <li>▪ Reading</li> <li>▪ Limit setting</li> <li>▪ Involvement at school</li> <li>▪ Teacher conferences</li> </ul>	Parent	Home-school connection

(continued)

TABLE 1 (Continued)

Interventions	Skills targeted	Person trained	Setting targeted
Child skills training (KIDVID)	<ul style="list-style-type: none"> <li>■ Social skills</li> <li>■ Friendship</li> <li>■ Teamwork</li> <li>■ Cooperation, helping</li> <li>■ Communication</li> </ul> <p>Problem solving</p> <ul style="list-style-type: none"> <li>■ Anger management</li> <li>■ Steps 1-7</li> </ul> <p>Classroom behavior</p> <ul style="list-style-type: none"> <li>■ Quiet hand up</li> <li>■ Compliance</li> <li>■ Listening</li> <li>■ Stop-look-think-check</li> <li>■ Concentrating</li> </ul>	Child	Home and school
Teacher training (PARTNERS 2)	Classroom management skills Promoting parent involvement	Teacher	School

ents will perceive at least some of the models as similar to themselves and their children, and will therefore accept the tapes as relevant. Videotapes show parent models (unrehearsed) in natural situations with their children "doing it right" and "doing it wrong" to demystify the notion there is perfect parenting and to illustrate how one can learn from one's mistakes. This approach also emphasizes our belief in a coping and interactive model of learning (Webster-Stratton, 1981b); that is, parents view a videotape vignette of a parent doing it wrong and then discuss how the parent might have handled the interaction more effectively. This approach serves not only to enhance parents' confidence in their own ideas but also to develop their ability to analyze different situations with their children and select an appropriate parenting strategy. In this regard, our training differs from other parent training programs wherein the therapist provides the analysis and recommends a particular strategy.

The BASIC parent training program takes 26 hours, or 13–14 weekly sessions. It encompasses 10 videotape programs of modeled parenting skills (250 vignettes, each of which is approximately 1–2 minutes long) shown by a therapist to groups of parents (8–12 parents per group). The videotapes demonstrate behavioral principles and serve as the stimulus for focused discussions, problem solving, and collaborative learning. The program is also designed to help parents understand what are normal variations in children's development, emotional reactions, and temperaments. After each vignette, the therapist works with parents by soliciting their ideas and involving them in the process of problem solving, sharing, and discussing ideas and reactions. We see the therapists' role as one of supporting and empowering parents by teaching, leading, reframing, predicting, and role playing, always within a collaborative context (Webster-Stratton & Herbert, 1993, 1994). The collaborative context is designed to ensure that the intervention is sensitive to individual cultural differences and personal values. The program is tailored to each family's individual needs and goals, as well as to each child's personality and behavior problems.

Our program implies a commitment to parental self-management. We believe that this approach empowers parents by giving back dignity, respect, and self-control to parents who are often seeking help for their children's problems at a vulnerable time of low self-confidence and intense feelings of guilt and self-blame. By using the group process, the program is not only more cost effective but also addresses important risk factors for conduct disorders: the family's isolation and stigmatization. The parent groups provide a parent support group that becomes a model for parent support networks. (For details of therapeutic processes, please see Webster-Stratton & Herbert, 1994.)

The first two segments of the BASIC program focus on teaching parents to play with their children—interactive and reinforcement skills. This material is derived from the early research of Hanf (1970) and Robinson

and Eyberg (1981). The third and fourth segments teach parents a specific set of nonviolent discipline techniques including commands, time out, and ignore as described by Patterson (1982) and Forehand and McMahon (1981), as well as logical and natural consequences and monitoring. The fourth segment also shows parents how they can teach their children problem-solving skills (D'Zurilla & Nezu, 1982; Spivak, Platt, & Shure, 1976). Table 2 provides a brief description of the content of each program.

## Family Training Interventions

### *Rationale for Broader-Based Training*

In addition to parenting behavior, other aspects of parents' behavior and personal lives constitute risk factors for child conduct problems. Researchers have demonstrated that personal and interpersonal factors, such as parental depression, marital discord, lack of social support, and environmental stressors, disrupt parenting behavior and contribute to relapses after the parent training (e.g., Dumas, 1984; Webster-Stratton, 1990b, 1990c). In our own analysis of the marital status of 218 parents of children with ODD and CD, we found that 36% were single (defined as divorced, separated, and not currently living with a partner for more than 3 months). Of the remaining 140 subjects (67%) who were married or had been living with a partner for more than 3 months, nearly half (49%) reported significant marital distress (scores of less than 100 on the marital adjustment scale or experiences with spouse abuse). Of the maritally distressed group, 31% were second or third marriages. Of the half that reported supportive marriages, 23% were in second or third marriages. In summary, 75% of the sample had been divorced at least once or were currently in stressful marriages. Half of the married couples reported current experiences with spouse abuse. These findings highlight the importance of marital conflict as a potential key factor influencing the development of conduct disorders. This research is corroborated by the earlier work of Rutter, Cox, Tupling, Berger, & Yule (1975), who reported that marriages characterized by tension and hostility were associated more closely with children's behavior disturbances than marriages characterized by apathy and indifference. The role played by the parents' open conflict and expression of negative affect is further emphasized in studies of parents in laboratory situations either requiring interpersonal negotiation or provoking discord (Love & Kaswan, 1974). Studies suggest that factors such as children's exposure to marital conflict (Grych & Fincham, 1990; Porter & O'Leary, 1980), physical aggression between spouses, and disagreements over child rearing (Jouriles, Murphy, & O'Leary, 1989) account for variance beyond that of general marital stress in a control sample.



**TABLE 2**  
**Parenting Skills Training Intervention (BASIC)**

Content	Objectives	Content	Objectives
Part 1: How to play with a child	<ul style="list-style-type: none"> <li>▪ Recognizing children's capabilities and needs</li> <li>▪ Providing positive support for children's play</li> <li>▪ Helping children develop imaginative and creative play</li> <li>▪ Building children's self-esteem and self-concept</li> <li>▪ Handling children's boredom</li> <li>▪ Avoiding power struggles with children</li> <li>▪ Understanding the importance of adult attention</li> </ul>	<b>Program 1: Play</b> Part 2: Helping children to learn	<ul style="list-style-type: none"> <li>▪ How to talk with children</li> <li>▪ Ways to foster language development</li> <li>▪ Building children's confidence in learning ability</li> <li>▪ How to help children learn to solve problems</li> <li>▪ Helping children deal with frustration</li> <li>▪ Avoiding the criticism trap</li> <li>▪ Making learning enjoyable through play</li> </ul>
Part 1: The art of effective praising	<b>Program 2: Praise and rewards</b> Part 2: Tangible rewards <ul style="list-style-type: none"> <li>▪ Understanding ways to praise more effectively</li> <li>▪ Avoiding praising only perfection</li> <li>▪ Recognizing common traps</li> <li>▪ Handling children who reject praise</li> <li>▪ Providing physical warmth</li> <li>▪ Recognizing child behaviors that need praise</li> <li>▪ Understanding the effects of social rewards on children</li> <li>▪ Doubling the impact of praise</li> <li>▪ Building children's self-esteem</li> </ul>	<b>Program 2: Praise and rewards</b> Part 2: Tangible rewards	<ul style="list-style-type: none"> <li>▪ Providing unexpected rewards</li> <li>▪ Understanding the difference between rewards and bribes</li> <li>▪ Recognizing when to use the "first-then" rule</li> <li>▪ Providing ways to set up star and chart systems with children</li> <li>▪ Recognizing ways to carry out point programs</li> <li>▪ Understanding how to develop programs that are age appropriate</li> </ul>

*(continued)*

TABLE 2 (Continued)

Content	Objectives	Content	Objectives
			<ul style="list-style-type: none"><li>• Understanding ways to use tangible rewards for problems such as dawdling, not dressing, noncompliance, not sharing, sibling fighting, picky eating, messy room, not going to bed, and soiled diapers</li></ul>
Program 1: How to set limits		Program 3: Effective limit setting	
	<ul style="list-style-type: none"><li>• Helping parents identify important household rules</li><li>• Understanding ways to give more effective commands</li><li>• Avoiding unnecessary commands</li><li>• Avoiding unclear, vague, and negative commands</li><li>• Providing children with positive alternatives</li><li>• Understanding when to use the "when-then" command</li><li>• Recognizing the importance of warnings and helpful reminders</li><li>• Understanding ways to use problem-solving approaches</li></ul>	Part 2: Helping children to learn to accept limits	<ul style="list-style-type: none"><li>• Dealing with children who test the limits</li><li>• Understanding when to divert and distract children</li><li>• Avoiding arguments and "why games"</li><li>• Recognizing traps that children set for parents</li><li>• Ignoring inappropriate responses</li><li>• Following through with commands effectively</li><li>• Helping children to be more compliant</li></ul>

**Part 3: Dealing with noncompliance**

- Understanding how to implement time out for noncompliance
- Understanding ways to explain time out to children
- Avoiding power struggles
- Dealing with the child who refuses to go to time out or refuses to stay in time out
- Ignoring children's inappropriate responses
- Following through effectively and consistently
- Avoiding common mistakes concerning time out

**Part 1: Avoiding and ignoring misbehavior**

**Program 4: Handling misbehavior**  
**Part 2: Time out and other penalties**

- Anticipating and avoiding frustration
  - Showing disapproval
  - Ignoring and distracting
  - Handling noncompliance, screaming, arguing, pleading, and tantrums
  - Handling crying, grabbing, not eating, and refusing to go to bed
  - Encouraging sharing and cooperating between children
  - Using puppets and story books to teach children social skills
  - Effective talking and listening
  - Problem solving with children
  - Review of points to remember when using time out
- Explaining time out to a school-age child
  - Using time out for hitting behaviors
  - Using the time out chair with a toddler
  - Explaining time out to a toddler
  - Using a time out room with a toddler
  - Using time out to help stop sibling fights
  - Following through when a child refuses to go to time out
  - Spitting
  - Threats
  - Logical consequences
  - When discipline does not work
  - Telephone syndrome
  - TV syndrome

**Part 3: Preventive strategies**

This evidence linking parental factors other than parenting behavior (e.g., marital distress, social isolation and lack of support, and poor problem-solving ability) to child conduct problems and treatment relapses led us to expand our theoretical and causal model concerning conduct problems. Parents' personal and interpersonal factors may disrupt parent-child interactions and family systems (Patterson, 1986; Webster-Stratton, 1989a, 1990c; Webster-Stratton & Hammond, 1988; Whipple & Webster-Stratton, 1991). For example, rather than the child's conduct problems being the result of parenting deficits, we hypothesized that the child's conduct in general and poor peer interactions in particular are modeled from the marital interactions. The child learns communication and problem-solving styles directly from observing the parents' interactions. In our revised model, a conflict resolution deficit model, we hypothesized that parents with children who have conduct disorders have more general relational deficits in communication, conflict resolution skills, and affect regulation. We believe that these deficits are manifested in marital and interpersonal difficulties, inability to get support or cope with life stressors, problematic parenting, and difficulty in coping with child misbehaviors. These, in turn, exacerbate their ineffectual parenting and, thereby, contribute to the development of child conduct problems (Dadds, Schwartz, & Sanders, 1987; Griest, Forehand, Rogers, Breiner, Furey, & Williams, 1982).

#### *Content of ADVANCE Parent Training Videotape Modeling Programs*

In light of this research and of the results of our long-term follow-ups indicating the potency of marital distress and divorce as predictors of treatment relapse, we developed the ADVANCE treatment program in 1989. We theorized that a broader-based training model (i.e., one involving more than parenting training) would help mediate the negative influences of these personal and interpersonal factors on parenting skills and promote increased maintenance and generalizability of treatment effects. This program has the same theoretical basis as the BASIC parent skills training program, namely, cognitive social learning theory. The therapeutic process and methods are also the same as those of the BASIC program because our prior research had indicated that therapist-led parent group discussions and interactive videotape modeling techniques were highly effective methods of producing behavior change and of promoting interpersonal support. Moreover, it was theorized that the group approach would provide more social support and decrease feelings of isolation for parents. Finally, it would be a cost-effective alternative to the conventional format of individual marital or interpersonal therapy.

The content of this 14-session videotape program (60 vignettes), which is offered following the completion of the BASIC training program, involves four components:

1. *Personal self-control.* Parents are taught to substitute coping and positive self-talk for their depressive, angry, blaming self-talk. This therapy component builds on the well-established research and clinical writings of Beck (1979), Lewinsohn, Antonuccio, Steinmetz, & Teni (1984), and Meichenbaum (1977). In addition, parents are taught specific anger management techniques.
2. *Communication skills.* Parents are taught to identify blocks to communication and to learn the most effective communication skills for dealing with conflict. This component builds on the communication work of Gottman, Notarius, Gonso, and Markman (1976) and the social learning-based marital treatment developed by Jacobson and Margolin (1979).
3. *Problem-solving skills.* In segments 6 and 7 of the videotape, parents are taught effective strategies for coping with conflict, with spouses, employers, extended family members, or children. These segments build on the research by D'Zurilla and Nezu (1982), but are also influenced by the marital programs of Gottman, Notarius, Gonso, and Markman (1976) and Jacobson and Margolin (1979).
4. *Strengthening social support and self-care.* This concept is woven throughout the group sessions by encouraging the group members to ask for support when necessary and to give support to others (see Table 3).

### **Academic Skills Training Intervention for Parents**

#### *Rationale for Academic Skills Training*

In follow-up interviews with parents who had completed our parent training programs, 58% requested guidance on how to encourage their children to do their homework, how to handle resistance; how to communicate with teachers concerning their children's behavior problems at school; and how to promote their children's reading, academic, and social skills. These data suggested a need for teaching parents how to access schools, collaborate with teachers, and supervise children's peer relationships. In addition, 40% of teachers reported problems with children's compliance and aggression in the classroom and requested advice on how to manage these problems. Clearly, integrating interventions across settings (home and school) and agents (teachers and parents) to target school and family risk factors

TABLE 3  
Interpersonal Skills Training Intervention (ADVANCE)<sup>a</sup>

Content	Objectives	Content	Objectives
Part 1: Active listening and speaking up	<p><b>Program 5: How to communicate effectively</b></p> <ul style="list-style-type: none"> <li>■ Understanding the importance of active listening skills</li> <li>■ Learning how to speak up effectively about problems</li> <li>■ Recognizing how to validate another's feelings</li> <li>■ Knowing how and when to express one's own feelings</li> <li>■ Avoid communication "blocks" such as not listening, storing up grievances, and angry explosions</li> </ul>	Part 2: Communicating more positively to oneself and to others	<ul style="list-style-type: none"> <li>■ Understanding the importance of recognizing self-talk</li> <li>■ Understanding how angry and depressive emotions and thoughts can affect behaviors with others</li> <li>■ Learning coping strategies to stop negative self-talk</li> <li>■ Learning coping strategies to increase positive self-talk</li> <li>■ Increasing more positive and polite communication with others</li> <li>■ Avoiding communication "blocks" such as put-downs, blaming, and denials</li> <li>■ Understanding the importance of seeing a problem from the other person's point of view</li> </ul>
Part 3: Giving and receiving support	<ul style="list-style-type: none"> <li>■ Understanding the importance of support for a family or an individual</li> <li>■ Recognizing communication styles or beliefs that block support</li> <li>■ Fostering self-care and positive self-reinforcement strategies in adults and children</li> <li>■ Avoiding communication "blocks" such as defensiveness, denials, cross complaints, inconsistent or mixed messages</li> </ul>		

- Knowing how to get feedback from others
- Understanding how to turn a complaint into a positive recommendation
- Promoting consistent verbal and nonverbal messages
- Knowing how to make positive requests of adults as well as children
- Understanding why compliance to another's requests is essential in any relationship
- Learning how to be more supportive to others

#### Program 6: Problem solving for parents

##### Part 2: Family problem solving

- Understanding how to use the six problem-solving steps with school-aged children
- Recognizing the importance of evaluating plans during each problem-solving session
- Understanding the importance of rotating the leader for each family meeting
- Learning how to help children express their feelings about an issue
- Reinforcing the problem-solving process

##### Part 1: Adult problem solving

- Recognizing when to use spontaneous problem-solving skills
- Understanding the six important steps to solve problems
- Learning how and when to collaborate effectively
- Avoiding "blocks" to effective problem solving such as blaming, attacks, anger, side-tracking, lengthy problem definition, missed steps, and criticizing solutions
- Recognizing how to use problem-solving strategies to get more support
- Learning how to express feelings about a problem without blaming

(continued)

TABLE 3 (Continued)

Content	Objectives	Content	Objectives
Part 1: Teaching children to solve problems through stories and games	<p><b>Program 7: Problem solving with children</b></p> <ul style="list-style-type: none"> <li>■ Understanding a variety of games and stories that can be used to help children begin to learn problem-solving skills</li> <li>■ Appreciating the developmental nature and process of problem solving and learning how to enhance these skills in children</li> <li>■ Strengthening a child's beginning empathy skills or ability to understand a problem from another person's viewpoint</li> <li>■ Recognizing why both aggressive and shy children need to learn these skills</li> <li>■ Learning how to help children think about the feeling and behavioral consequences to solutions proposed</li> </ul>	Part 2: Teaching children to solve problems in the midst of conflict	<ul style="list-style-type: none"> <li>■ Understanding the importance of adults not imposing solutions on children but fostering a thinking process about conflict</li> <li>■ Recognizing how and when to use guided solutions for very young children or for children who have no positive solutions in their repertoire</li> <li>■ Discovering the value of first obtaining the child's feelings and view of the problem before attempting to solve the problem</li> <li>■ Learning how to foster children's empathy skills and ability to perceive another's point of view</li> </ul>



- Knowing how to help older children evaluate their proposed solutions
  - Understanding the importance of validating children's feelings
  - Avoiding "blocks" to effective problem solving with children such as lectures, quick solutions, judgments, criticisms, too many questions, and exclusive focus on proper solutions
  - Learning how to help children make more positive attributions about another person's intentions
  - Recognizing the value of adults modeling their own problem solving for children to observe
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- Recognizing when children may be ready to solve problems on their own
  - Avoiding "blocks" to effective problem solving with children such as lectures, negative or quick judgments, exclusive focus on the right response and failure to validate a child's feelings

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\*BASIC and ADVANCE have been incorporated into our current version of training called FAMILY training.

fosters greater between-environment consistency and offers the best possibility for long-term reduction of antisocial behavior.

### *Content of PARTNERS Academic Skills Training*

Over the past 2 years, we have developed an interactive videotape modeling, academic skills training intervention (PARTNERS 1) as an adjunct to our parent skills and family intervention. This intervention consists of 6–8 additional sessions beyond the BASIC and ADVANCE programs. It focuses on collaboration with teachers and fostering children's academic readiness and school success through parental involvement in school activities, homework, and peer monitoring. This program's methods are consistent with the BASIC and ADVANCE interventions: videotape modeling, role playing, homework, and therapist-led group discussion. We have recently been funded to examine the added effectiveness of combining this new, academic skills, parent training program with our parent training interventions.

This six-session program involves six components (see Table 4 for summary):

1. *Promoting children's self-confidence.* Parents are taught to lay the foundation for their children's success in school by helping their children feel confident in their own ideas and in their ability to learn. Specifically, we teach parents how to prepare their children for reading; how to foster language development and problem solving; and how to promote children's reading, writing, and story-telling skills.
2. *Fostering good learning habits.* Parents are taught to establish a predictable homework routine, set limits concerning television and computer games, and follow through with consequences for children who test these limits.
3. *Dealing with children's discouragement.* Parents are taught how to set realistic goals for their child and how to increase gradually the difficulty of the learning task as the child acquires mastery, using praise, tangible rewards, and attention to motivate and reinforce progress.
4. *Participating in homework.* Parents are taught ways in which to play a positive and supportive role in their children's homework.
5. *Using teacher–parent conferences to advocate for your child.* This segment shows parents how to collaborate with their children's teachers to develop jointly plans to address their children's difficulties, such as inattentiveness, tardiness, and aggression in school.

TABLE 4  
Academic Skills Training Intervention for Parents (PARTNERS 1)

Content	Objectives	Content	Objectives
Part 1: Promoting your children's self-confidence	<p><b>Program 8: How to support your child's education</b></p> <ul style="list-style-type: none"> <li>■ Recognizing the capabilities of young children</li> <li>■ Providing positive support for children's play</li> <li>■ Helping children develop imaginative and creative play</li> <li>■ Building children's self-esteem and self-confidence in their learning ability</li> <li>■ Making learning enjoyable through play</li> <li>■ Teaching children to problem-solve</li> <li>■ Understanding the importance of adult attention and listening skills for children</li> <li>■ Fostering children's reading skills and storytelling through interactive dialogues, praise, and open-ended questions</li> </ul>	Part 2: Fostering good learning habits	<ul style="list-style-type: none"> <li>■ How to set up a predictable routine</li> <li>■ Understanding how television interferes with learning</li> <li>■ Effective limit-setting regarding homework</li> <li>■ Understanding how to follow through with limits</li> <li>■ Understanding the importance of parental monitoring</li> <li>■ Avoiding the criticism trap</li> </ul>
Part 3: Dealing with children's discouragement	<ul style="list-style-type: none"> <li>■ Helping children to avoid a sense of failure when they cannot do something</li> <li>■ Recognizing the importance of children learning according to their developmental ability and learning style</li> </ul>	Part 4: Participating in homework	<ul style="list-style-type: none"> <li>■ Understanding the importance of parental attention, praise, and encouragement for children's homework activities</li> <li>■ Recognizing that every child learns different skills at different rates according to their developmental ability</li> </ul>

(continued)

TABLE 4 (Continued)

Content	Objectives	Content	Objectives
Part 5: Using parent-teacher conferences to advocate for your child	<ul style="list-style-type: none"> <li>■ Understanding how to build on children's strengths</li> <li>■ Knowing how to set up tangible reward programs to help motivate children in a difficult area</li> <li>■ Understanding how to motivate children through praise and encouragement</li> <li>■ Understanding the importance of parental advocacy for their children in school</li> <li>■ Understanding how to focus on finding solutions to children's school difficulties (not blame)</li> <li>■ Recognizing effective communication and problem-solving strategies for talking to teachers</li> <li>■ Knowing ways to support teachers in their teaching efforts</li> <li>■ Recognizing strategies to motivate children at school</li> <li>■ Understanding the importance of continuity from home to school</li> </ul>		<ul style="list-style-type: none"> <li>■ Understanding how to build on children's strengths</li> <li>■ Understanding how to show active interest in children's learning at home and at school</li> </ul>

6. *Discussing a school problem with your child.* In this segment, parents are taught how to talk with their children about academic problems and how to set up a plan with them to maximize their success at school.

## TREATMENT EFFECTIVENESS OF BASIC AND ADVANCE PARENT INTERVENTIONS

### Short- and Long-term Outcome

Researched in a series of five randomized studies, our videotape modeling group discussion program (BASIC) has been shown to be effective in improving parental attitudes and parent-child interactions, along with reducing parents' reliance on violent disciplinary approaches and reducing child conduct problems, when compared with control groups and other treatment approaches (Webster-Stratton, 1981a, 1982a, 1982b, 1984, 1990a; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). In the initial study, the BASIC program was shown to be highly effective in improving parent and child behaviors in comparison with a control group. Behavioral observations indicated that treated mothers contradicted, intruded, and corrected less; they were less critical of their children and more positive. Children, in turn, were more independent and less negative and domineering when interacting with their mothers. Nearly identical changes occurred in the delayed treatment control group after completing the program. In the second randomized study with low-income single mothers of highly conduct-disordered children, the therapist-led BASIC program was shown to be as effective as the individualized one-to-one parent training with a therapist using "bug-in-the-ear" feedback (a procedure wherein the parent wears a small cordless microphone in the ear so that the therapist may coach the parent through a one-way mirror as the parent interacts with the child) and individual coaching (Webster-Stratton, 1984). However, the BASIC program was five times more cost-effective, using 48 hours of therapist time versus 251 hours in the one-to-one program.

Our third study was conducted to ascertain which element of the overall BASIC program (group support and discussion, therapist leadership, or videotape modeling) contributed most to its effectiveness. It was crucial to understand the independent role of each of these elements. Results indicated that all three treatment conditions resulted in significant improvements in comparison to the control group; when there were differences, the combined BASIC treatment was favored consistently (Webster-Stratton, 1989b; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). However, the completely self-administered (individually) intervention

(IVM), that is, without therapist feedback or group support, was also shown to be modestly effective (Webster-Stratton, 1990a, 1992). One year later, 93.1% of families were assessed on the basis of teacher and parent reports and home observations. Results indicated that all the significant improvements reported immediately post-treatment were maintained. Moreover, two-thirds of the entire sample showed "clinically significant" improvements (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989).

Three years after treatment, by which time all the children were enrolled in school, we assessed 82.1% of the families again to determine the presence of long-term differences among treatment groups in terms of numbers of relapses and children's functioning at school and at home. Follow-up reports from parents and teachers indicated overall improvements in child behavior when compared to baseline behavior reports. However, only the combined videotape modeling group-discussion treatment (BASIC) achieved stable improvements; the other two treatment groups showed significant relapses. These data suggest the importance of therapist leadership and parent group support used in conjunction with videotape modeling in producing the most effective results. In sum, these studies have indicated that videotape modeling, plus parent group discussion (BASIC), is not only an effective therapeutic method in terms of producing significant behavior change, which generalizes from home to school and over time, but is also highly cost effective, with good consumer satisfaction regardless of the parents' educational or socioeconomic background (Webster-Stratton, 1990b).

Evaluation of the clinical significance of the treatment programs indicated that, after 3 years, 25% to 46% of parents were concerned about school-related problems, such as peer relationships, aggression, noncompliance, and academic underachievement. Data from parents pointed to a need to help parents to become more effective in supporting their child's education and to collaborate with their child's teacher in addressing their child's social and academic difficulties. Data from teachers revealed a need to expand the intervention to include training for teachers in ways to manage classroom behavior problems and in ways to collaborate with parents (Webster-Stratton & Hammond, 1990; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). These data led us to develop the parent, academic skills training intervention described earlier and, more recently, to develop a teacher training component (PARTNERS 2), which is currently under evaluation.

Of particular interest were the findings in the third study regarding the totally self-administered treatment. In contrast with the control families, the IVM treatment resulted in significant improvements in child conduct difficulties (as reported by parents) and in parent-child interactions (according to independent observers). These findings are remarkable in light of the fact that these multiproblem families had no direct therapist contact or group support throughout the entire training series and suggest

that parents who are motivated can learn to change their own and their children's behaviors by means of a self-administered program. Clearly, this program has major implications for treatment and prevention.

Nonetheless, although the IVM treatment was extremely cost effective, it was not as potent as the BASIC treatment in terms of consumer satisfaction and long-term effects. Consequently, we sought to determine how to enhance the effectiveness of IVM treatment while maintaining its cost effectiveness. Because IVM families saw the lack of personal contact with a therapist as a limitation of the program, we added brief therapist consultation to the IVM program. Comparing IVM, IVM plus therapist consultation (IVMC), and a waiting-list control group at pretreatment, posttreatment, and 1 year later, our fourth study found that both treatment groups of mothers reported significantly fewer child behavior problems, reduced stress levels, and less use of spanking than those in the control group. Home-visit data indicated that both treatment groups exhibited significant behavioral changes, which were maintained 1 year later. There were relatively few differences between the two treatment conditions on the outcome measures. However, the IVMC children were significantly less deviant than the IVM children, suggesting that therapist consultation improves this treatment approach (Webster-Stratton, 1990a, 1990b, 1992). These findings have implications for reaching many more families in cost-effective treatment or prevention programs to help prevent behavior difficulties from escalating in the first place.

In a fifth study, we examined the effects of adding the ADVANCE intervention component to the BASIC intervention. Parents of 78 families with children with ODD and CD received the initial BASIC parent training and, then, were randomly assigned to either ADVANCE training or no additional contact. Families were assessed at baseline, and at 1 month, 1 year, and 2 years posttreatment by parent and teacher reports of child adjustment and parent distress (i.e., depression, anger, and stress), as well as by direct observations of parent-child interactions and marital interactions (discussing a problem). For both treatment groups, there were significant improvements in child adjustment and in parent-child interactions and a decrease in parent distress and child behavior difficulties. These changes were maintained at follow-up. ADVANCE children showed significant increases in the total number of solutions generated during problem solving, most notably in prosocial solutions (as compared with aggressive solutions) in comparison with their counterparts. Observations of parents' marital interactions indicated significant improvements in ADVANCE parents' communication, problem-solving, and collaboration skills when compared with parents who did not receive ADVANCE. Only one family dropped out of the ADVANCE program, which attests to its perceived usefulness by families. All the families attended more than two-thirds of the sessions with the majority attending more than 90% of

sessions. ADVANCE parents reported significantly greater consumer satisfaction than did parents who did not receive ADVANCE, with parents reporting the problem-solving skills to be the most useful and anger management the most difficult.

Next, we looked at how clinically significant improvements (30%) in parents' communication and problem-solving skills were related to improvements in their parenting skills. We found that, in the case of fathers, improvement in marital communication skills was related to a significant reduction in the number of criticisms in their interactions with their children; fathers' improved marital communication was also related to improvements in the child's prosocial skills. These results indicate the importance of fathers' marital satisfaction as a determining factor in their parenting skills. Overall, these results suggest that focusing on helping families to manage personal distress and interpersonal issues through a videotape modeling group discussion treatment (ADVANCE) is highly promising, in terms of (a) improvements in marital communication, problem-solving, and coping skills; (b) improvements in parenting skills; (c) improvements in children's prosocial skills; and (d) consumer satisfaction, that is, being highly acceptable and perceived as useful by families (Webster-Stratton, 1994).

#### Parent Training Treatment Limitations

As reported earlier, we have followed families longitudinally (1, 2, and 3 years posttreatment) and have assessed not only the statistical significance of treatment effects but also their clinical significance. In assessing the clinical significance, three criteria were used: (a) the extent to which parent and teacher reports indicated that the children were within the normal or (b) within the nonclinical range of functioning (Jacobson, Follette, & Revenstorf, 1984); and (c) whether families requested additional therapy for their children's behavior problems at the follow-up assessments. These outcome criteria were chosen to avoid reliance on a single informant or criterion measure, thereby providing greater validity for the findings. In our 3-year follow-up of 83 treated families, we found that 25–46% of parents and 26% of teachers still reported clinically significant child behavior difficulties (Webster-Stratton, 1990b). These findings are similar to other long-term treatment outcome studies that suggest that 30–50% of families relapse or fail to show continuous long-term benefits from treatment (e.g., Jacobson, Schmalings, & Holtzworth-Monroe, 1987; McMahon & Forehand, 1984; Wahler & Dumas, 1984).

We also found that the families, whose children had continuing externalizing problems (according to teacher and parent reports) at our 3-year follow-up assessments, were characterized by maritally distressed or single-parent status; increased maternal depression; lower social class; high



levels of negative life stressors; and family histories of alcoholism, drug abuse, and spouse abuse (Webster-Stratton, 1990a, 1990b, 1990c; Webster-Stratton & Hammond, 1990). These predictors of poor outcome emerged regardless of whether the intervention was the combined BASIC program or the IVM condition. These prediction studies were limited, however, in that they examined only one predictor at a time and relied largely on predictors related to mothers' psychological status or perceptions (not fathers'). Most recently, we attempted to determine whether some of these predictors are more powerful than others and the extent of amplification among predictors. The best predictor of the amount of child deviance for home observations was single-parent status or marital adjustment. For families who had a father present, the degree of negative life stress experienced by the father in the year after treatment was the best predictor of child deviance. Marital status was the best predictor of teacher reports of child adjustment (Webster-Stratton & Hammond, 1990). Thus, divorce, marital distress, and negative life stress were the key predictors in determining the child's long-term treatment outcome. Thus, we hypothesize that, by strengthening families' coping skills and marital communication in the ADVANCE program, we may be able to improve the long-term results.

### Summary and Significance

In focusing on parenting training, we were targeting the most proximal links in the development of conduct disorders. We hypothesized that, because parents are the most powerful—and potentially malleable—influence on young children's social development, intervening with parents would be the most strategic first step. Indeed, our studies have shown that videotape modeling parent training is highly promising as an effective therapeutic method for producing significant behavior change. It has received good consumer satisfaction reports, regardless of parents' educational or socioeconomic background (Webster-Stratton, 1989b). Approximately 65% of families achieved sustained improvements in their children's conduct disorders. Moreover, our effects were further enhanced when we targeted other parental risk factors, such as marital distress, anger management, and maternal depression. These interventions strengthened parental coping skills and helped buffer the disruptive effects of these personal and interpersonal stressors on parenting and on children's social development. Nonetheless, when we looked at predictors of relapse and the failure of improvements in child behaviors to generalize beyond home to school and peer relationships, our long-term data suggested that our model, concerning the development of conduct problems, was incomplete.

## Child Social Skills Training Intervention

### *Rationale for Child Training Intervention*

One reason for which the improvements in child behavior resulting from parenting training did not generalize from home to school might be the exclusive focus on parent skills as the locus of change, that is, the lack of attention to the role that child factors play in the development of conduct problems. Indeed, research has indicated that children with ODD and CD have some neurological, physiological, and temperament difficulties that contribute to their difficulties with peers and to the parenting difficulties of their parents. Studies have suggested that children with conduct disorders are more hyperactive and impulsive (Lillenfield & Waldman, 1990), are more likely to have difficulty solving social problems (Rubin & Krasnor, 1986), and respond with more agonistic and incompetent strategies to hypothetical conflict situations (Milich & Dodge, 1984; Richard & Dodge, 1982). Aggressive children also search for fewer cues or facts when determining another person's intentions (Dodge & Newman, 1981), focus more on aggressive cues (Goutz, 1981), are more likely to misattribute hostile intentions to others (Dodge, 1985), and are less empathic than their nonaggressive peers (Ellis, 1982). This line of research suggests that children with conduct disorders lack the critical cognitive, social, and behavioral skills needed for positive interactions; it has spawned what has been termed the *child-deficit hypothesis* by Asher and Renshaw (1981).

Those who subscribe to this child-deficit model have developed cognitive-behavioral interventions to train children directly in social and problem-solving skills (Dodge, Price, Bachorowski, & Newman, 1990; Kendall, 1985; Rubin & Krasnor, 1986; Spivak, Platt, & Shure, 1976). A review of this research is encouraging (Kendall & Braswell, 1985), especially for improving older children's social skills at school. However, such improvements have not been shown to generalize to other settings (e.g., the home). Also, a large proportion of children appears to be relatively unaffected by treatment, particularly the younger, the cognitively less mature, and the more aggressive children (Asher & Coie, 1990).

We hypothesized that there were several reasons why existing social skills programs had not been able to help younger children with conduct problems. First, many of these programs were originally developed for older adolescents and subsequently applied to younger age groups; as a consequence, these programs were not developmentally appropriate for young preschool children (who are preoperational in their thinking). Second, existing programs did not focus specifically on the child's aggression and noncompliance, nor did they address these children's specific academic difficulties. Third, some child social skills programs did not involve a parent or family training component, a limitation that would seem to make gen-

eralizing to other settings less likely. We hypothesized that a comprehensive intervention, combining a parent training component with a child training component specifically designed for young, aggressive children, would be more effective than either component alone.

### *Content and Process of the KIDVID Child Social Skills and Problem-Solving Training Intervention (Dinosaur Curriculum)*

In 1990, we developed a new videotape modeling child training program (KIDVID) for conduct-problem children (ages 3–8 years). Our efforts to create a developmentally appropriate, theory-based intervention for aggressive preschool and early-school-aged children were guided both by the available literature and by our own observations comparing oppositional-defiant and conduct-disordered children with behaviorally normal children. Traditional social skills training programs typically did not have content that was directly relevant to conduct disorder and aggression. Our program targets selected child risk factors (problem-solving and social skills deficits, peer rejection, loneliness, and negative attributions) and uses the child directly as an agent of change. The intervention is designed to enhance children's school behaviors, promote social competence and positive peer interactions, as well as nonaggressive conflict management strategies. In addition, the program teaches children how to integrate themselves successfully into the classroom and how to develop friendships.

This 22-week program consists of a series of nine videotape segments (more than 100 vignettes) that teach children problem-solving and social skills. Organized so as to dovetail with the content of the parent training program, the program consists of seven main components:

1. introduction and rules (1–2 sessions);
2. empathy training (2–3 sessions);
3. problem-solving training (3–4 sessions);
4. anger control (2–3 sessions);
5. friendship skills (3–4 sessions);
6. communication skills (2–3 sessions); and
7. school training.

The children come to our clinic once a week to meet in small groups of six children for 2 hours. In this curriculum, we use videotape modeling examples in every session to foster discussion, problem solving, and modeling of prosocial behaviors. To enhance generalization, the scenes selected for each of the units involve real-life conflict situations at home and at school (playground and classroom), such as teasing, lying, stealing, and destructive behavior. For example, the videotapes show children of differing ages, sexes, and cultures interacting with adults (parents or teachers) or with other children "doing it right" or "doing it wrong." Then, the tapes

are paused so that the children can discuss feelings and generate ideas for more effective responses and role-play alternative scenarios. In addition to interactive videotape modeling teaching, the therapists use life-size puppets to model appropriate behavior and thinking processes for the children. The use of puppets appeals to children on the fantasy level, so predominant in this preoperational age group. Because young children are more vulnerable to distraction, are less able to organize their thoughts, and have poorer memories, we use a number of strategies for reviewing and organizing the material to be remembered

1. playing Copy Cat to review skills learned;
2. videotape examples of the same concept in different situations and settings;
3. cartoon pictures and specially designed stickers used as cues to remind children of key concepts;
4. role playing with puppets and other children to provide not only practice opportunities but also experience with different perspectives;
5. reenacting videotape scenes;
6. visual story examples of key ideas;
7. play, art, and game activities to rehearse skills;
8. homework to practice key skills; and
9. letters to parents and teachers explaining the key concepts that the children are learning and asking them to reinforce these behaviors whenever they see them occurring throughout the week.

For example, if the concept being taught is teamwork, teachers and parents will be asked to reinforce examples that they see of children sharing, helping, and cooperating during the week and to give the child a note about these behaviors, which is to be brought to the next session (special Dinosaur notes are given to teachers and parents, which they may use with the children). See Table 5 for a summary of the content of the KIDVID program.

## CHILD TRAINING TREATMENT EFFECTIVENESS

Families of 97 children with early-onset conduct problems, aged 4–8 years, were randomly assigned to one of four conditions: a treatment group that received the FAMILY intervention (including BASIC parenting skills training as well as ADVANCE interpersonal training), a treatment group that received the child training program (KIDVID), a treatment group that received both the parent and child training programs, or a waiting-list control group (CON). We hypothesized that families who received the

**TABLE 5**  
**Child Social Skills and Problem-Solving Training (KIDVID)**

Content	Objectives	Content	Objectives
Making new friends and learning school rules	<p><b>Program 1: Wally Introduces Dinosaur School</b></p> <ul style="list-style-type: none"> <li>▪ Helping children understand the importance of rules</li> <li>▪ Helping children participate in the process of rule making</li> <li>▪ Understanding what will happen if rules are broken</li> <li>▪ Learning how to earn rewards for good behaviors</li> <li>▪ Promoting children's friendships</li> </ul>		
Wally teaches clues for detecting and understanding feelings	<p><b>Program 2: Understanding and detecting feelings</b></p> <ul style="list-style-type: none"> <li>▪ Learning words for different feelings</li> <li>▪ Learning how to tell how someone is feeling from verbal and nonverbal expressions</li> <li>▪ Increasing awareness of nonverbal facial communication used to portray feelings</li> <li>▪ Learning different ways to relax</li> <li>▪ Helping children understand why different feelings occur</li> <li>▪ Helping children understand feelings from different perspectives</li> <li>▪ Practicing talking about feelings</li> </ul>		

(continued)

TABLE 5 (Continued)

Content	Objectives	Content	Objectives
Parts 1, 2, and 3: Detective Wally teaches problem-solving steps	<b>Program 3: Detective Wally teaches problem-solving steps</b> <ul style="list-style-type: none"> <li>Learning how to identify a problem</li> <li>Thinking of solutions to hypothetical problems</li> <li>Learning verbal assertive skills</li> <li>Learning how to inhibit impulsive reactions</li> <li>Understanding what apology means</li> <li>Thinking of alternative solutions to problem situations, such as being teased and hit</li> <li>Learning to understand that solutions have different consequences</li> <li>Learning how to evaluate solutions critically, one's own and others'</li> </ul>	Parts 4 and 5: Detective Wally teaches how to control anger	<ul style="list-style-type: none"> <li>Recognizing that anger can interfere with good problem solving</li> <li>Understanding Tiny Turtle's story about managing anger and getting help</li> <li>Understanding when apologies are helpful</li> <li>Helping children recognize anger in themselves and others</li> <li>Helping children to understand that anger is okay to feel inside but not to act out by hitting or hurting someone else</li> <li>Learning how to control anger reactions</li> <li>Helping children understand that things that happen to them are not necessarily hostile or deliberate attempts to hurt them</li> <li>Practicing alternative responses to being teased, bullied, or yelled at by an angry adult</li> <li>Learning skills to cope with another person's anger</li> </ul>

**Program 4: Molly Manners teaches how to be friendly**

- Learning what teamwork means
- Understanding the benefits of sharing, helping, and teamwork
- Practicing friendship skills

**Part 1: Helping**

- Learning what teamwork means
- Understanding the benefits of sharing, helping, and teamwork
- Practicing friendship skills

**Part 2: Sharing**

- Learning what teamwork means
- Understanding the benefits of sharing, helping, and teamwork
- Practicing friendship skills

**Program 5: Molly Manners explains how to talk with friends**

- Learning how to ask questions and tell something to a friend
- Learning how to listen carefully to what a friend is saying
- Understanding why it is important to speak up about something that is bothering you
- Understanding how and when to give an apology or compliment
- Learning how to enter into a group of children who are already playing
- Learning how to make a suggestion rather than give commands
- Practicing friendship skills

**Program 6: Dina Dinosaur teaches how to do your best in school**

- Learning how to stop, think, and check work first
- Learning the importance of cooperation with the teacher and other children
- Practicing concentrating and good classroom skills

**Part 1: Listening, waiting, quiet hands up**

- Learning how to stop, think, and check work first
- Learning the importance of cooperation with the teacher and other children
- Practicing concentrating and good classroom skills

**Part 2: Concentrating, checking, and cooperating**

- Learning how to stop, think, and check work first
- Learning the importance of cooperation with the teacher and other children
- Practicing concentrating and good classroom skills

combined child and parent training programs would show greater improvement and more sustained results. Baseline, posttreatment, and 1-year follow-up assessments included parent and teacher reports, observations of parent-child interactions, observations of peer interactions during competitive play situations, and child social skills and problem-solving testing.

Posttreatment assessments indicated that all three treatment conditions result in significant improvements in comparison with control participants, as measured by mother and father reports, daily observations of targeted behaviors at home, and laboratory observations of interactions with a best friend. Comparisons of the three treatment conditions indicated that children who participated in KIDVID (with or without parent training) showed significant improvements in problem solving as well as in conflict management skills, as measured by independent observations of their interactions with a best friend; differences among treatment conditions on these measures consistently favored the KIDVID condition over the FAMILY condition. As for parent and child behavior at home, families who participated in one of the two conditions that involved parent training had significantly more positive parent-child interactions in comparison with families who participated only in the KIDVID training, as measured by independent observations.

One-year follow-up assessments indicated that all the significant changes noted immediately posttreatment were maintained over time in both the clinical and home settings. Moreover, child conduct problems at home had lessened significantly over time. Analyses of the clinical significance of the results suggested that the combined child and parent training intervention (FAMILY + KIDVID) produced the most significant improvements in child behavior at 1-year follow-up. However, children from all three treatment conditions showed increases in behavior problems at school 1 year later, as measured by teacher reports. (For more details about this study, see Webster-Stratton, 1995a).

## RECOMMENDATIONS AND FUTURE DIRECTIONS

It could also be argued that, for some families, the lack of long-term effectiveness of family programs and the failure of child behavior improvements to generalize, beyond the home, to school and to peer relationships may be attributable to the fact that the school environment and teachers themselves play a role in the development and maintenance of conduct disorders. Perhaps, an exclusive focus on parent and child skills is still too narrow to be effective as treatment or prevention.

Academic performance has been implicated in child conduct disorder. Children with conduct problems often manifest low academic achievement



during the elementary grades and on through high school (Kazdin, 1987). Reading disabilities, in particular, are associated with conduct disorder (Sturge, 1982). The overlap of underachievement in reading and aggressive behaviors occurs at rates well above chance levels (Rutter, Tizard, & Whitmore, 1970). One study indicated that the reading ability of children with conduct disorders lags 28 months behind that of normal children (Rutter, Tizard, Yule, Graham, & Whitmore, 1976). Furthermore, this relationship between poor academic performance and conduct disorder is not merely unidirectional, but may be bidirectional, that is, disruptive behavior problems and academic problems may lead to each other. It is clear that conduct problems and reading deficits place the child at high risk for lower self-esteem, continued academic failure, additional conduct disorders, and school dropout.

The school setting has also been studied as a risk factor contributing to conduct disorders. Rutter and his colleagues (1976) found that characteristics such as the degree of emphasis on academic work and individual responsibility, the amount of teacher time spent on lessons, the extent of the teacher's use of praise, the degree of teacher availability, and the teacher-student ratio were related to delinquency rates and academic performance. In light of the influence of the school environment and of teachers in particular on conduct disorders, it is surprising that training programs for parents of conduct-problem children have not, in general, involved teachers. Typically, teachers are left struggling alone in the classroom with a difficult child who exhibits academic as well as behavior difficulties. Moreover, in spite of the documented links among conduct problems and underachievement, language delays, and reading disabilities, there have been no attempts to increase the effectiveness of parent training programs by adding an academic skills training component for parents. Yet, parents need to know how to help their children not only with their antisocial problems, but also with their academic difficulties (e.g., reading and writing). In addition, parents need to know how to work with school personnel to foster a supportive relationship between home and school settings. Such a coordinated effort between home and school, regarding social and academic goals, might lead to better generalization of child improvements across settings. If intervention occurs when children are preschoolers, if it involves teachers as well as parents and children, and if it includes content related to school issues as well as home issues, the prognosis for preventing and reducing conduct problems would seem to be far more favorable than through more traditional parent training or child training programs. We currently have a study underway in which we are examining the added benefits of combining teacher training (PARTNERS 2, based on videotape modeling) with our parent and child interventions.

## SUMMARY

In summary, a review of our own research suggests that comprehensive interactive videotape family training methods are highly promising, especially for parents of young children with conduct difficulties. Even a self-administered videotape training format that did not involve a therapist or group support produced significant improvements in parent-child interactions and a reduction in conduct difficulty. However, treatment outcome was related directly to marital distress. Our most effective interventions involved videotape training not only in parenting skills, but also in marital communication, problem solving, and conflict resolution. These findings have pointed to the need for interventions that help strengthen families' protective factors, specifically, parents' interpersonal skills and coping skills, so that they may be able to cope more effectively with their added stresses. Our research has also suggested that videotape modeling is a highly effective strategy for building young conduct-problem children's social skills and problem-solving strategies. We hypothesize that a videotape-based academic skills enhancement program would further increase the effectiveness of intervention programs for families of children with conduct problems.

Our intervention studies may be viewed as an indirect test of theoretical models regarding the development of conduct disorders. We started with a simple parenting skills deficit model and have evolved to a more complex interactional model. In our current model we hypothesize that the child's eventual outcome will be dependent on the interrelationships among children, parents, teachers, and peers. Therefore, the most effective interventions should be those that involve schools, teachers, and the child's peer group. Such programs hold promise for prevention programs, which should be offered early to high-risk populations, before the disorder develops in the first place. We are currently collaborating with the Johns Hopkins University Prevention Center in a trial to evaluate the usefulness of a family component of our intervention programs as a prevention program in the early grades of a number of inner-city Baltimore schools. We have begun our own preventive research project with Puget Sound Educational Service District Head Start in Seattle to determine whether the development of conduct problems can be prevented through early interventions involving parent and teacher training. To date, 500 Head Start program families have participated in this trial, and initial baseline analysis has indicated that, according to mothers, 40% of the children exhibited aggressive and disruptive behaviors in the clinical range. Head Start centers were assigned randomly to two conditions: (a) an experimental condition in which parents, teachers, and family service workers participated in training (BASIC + PARTNERS 2); or (b) a control condition in which parents, teachers, and family service workers participated in their regular cen-

ter-based Head Start program. Parents in the experimental schools participated in an abbreviated prevention version of BASIC (8–9 group sessions). Preliminary short-term results are highly promising. Intervention mothers made significantly fewer critical remarks, used less physically negative discipline, and were more positive, appropriate, and consistent in their discipline style when compared with control mothers. Intervention children were observed to exhibit significantly fewer negative behaviors in the home, less noncompliance, more positive affect, and more prosocial behaviors than control children (Webster-Stratton, 1995b). Given the high base rates of ODD in this high risk sample of primarily single mothers on welfare and the continuity of the problem from early childhood, through adolescence, and often into adulthood (with its implication for the intergenerational transmission of deviance), the opportunity of breaking the link in the cycle of disadvantage is a public health matter of the utmost importance.

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