

Chapter 5

The Incredible Years Parent, Teacher and Child Programs: Foundations and Future

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Innovation of Incredible Years: Where We Have Been and Where Do We Go From Here?

Starting Point

At this late stage in my career I am often asked:

What prompted you to develop the Incredible Years (IY) programs 40 years ago? What was your motivation for the collaborative group and video mediated methods you used in your intervention programs to change parent, teacher, and child behaviors? Why did you choose a group collaborative approach over the traditional one-on-one approach? How did your research career come about?

As I look back now on my life journey, I confess there never was a master plan to become an academic professor, or to develop a business training others. Rather just the opposite, my primary goal was to become a better clinician to help families and children. The growth and development of the IY programs seems to have come about because of personal experiences, a particular passion, research studies, collective action, and ultimately a measure of serendipity.

Development of a Strategy and Theory of Change ~ Historical Roots

I believe that my love of children must have arisen from my 15 years of summers at a YMCA camp in Ontario, Canada both as a camper and then as a camp counselor. Modeling theory would also suggest that I was motivated to innovate and to bring about positive change in children's lives in part because my father was a model innovator, always working to make things better and accepting of the benefits of technology. In 1950, he filed a patent for the O'Cedar sponge mop that he designed so that people could stand while cleaning the floor, rather than be on their hands and knees. He encouraged my passion for photography, as I joined him in his dark room printing black and

white photos from film and later processing pictures in Photoshop and printing in digital format. I have been told by my parents that even as a baby I was fascinated by observing people, as apparently, my favorite activity was being harnessed and tied up to the clothes line, or put in my pram outside (regardless of temperature) to watch people. As a teenager, I loved taking pictures of people and I currently still love sharing my narrated picture-heavy travel blogs with friends. Ultimately, my photography and video obsession resulted in my developing video-based intervention programs for parents, teachers, and children, evaluating treatment outcomes via video observations, and using video to give feedback regarding clinician intervention sessions and to assess trainer workshop effectiveness. My early experiences working in a dark room with film progressed to the editing and reproduction of digital video pictures via the computer, and taught me to expect change and to learn from it.

Several key mentors in my early 20s influenced my philosophy of helping others and my theory of how people might be motivated to change their habits. After completing my training as a nurse at the University of Toronto, I worked in Sierra Leona, Africa with an African physician. The goal for me was to train local people to help pregnant women eat healthier food and to breast feed rather than bottle feed in order to reduce malnutrition and mortality. While teaching women to eat more nutritious foods to increase their babies' birth weights seems like a goal that mothers would embrace, I found my advice was resisted or ignored. I had brought a generator with me so that I could show slides of people eating healthy foods and urinating in designated spots (so as to prevent schistosomiasis). This slide show in 1969 seemed like magic to the African people as they had not previously seen what photographic images came from cameras. So, while my teaching efforts did not change behavior, they did provide good entertainment and much laughter. Before long I learned that the reason these mothers did not eat much during pregnancy was because they did not want to have big babies that they could not deliver due to their own poor health history, including Rickets disease and flattened pelvises. Large babies were more likely to lead to serious tears and fistulas that could not be surgically fixed. I also learned that mothers bottle fed rather than breast fed because they believed powdered milk sent to them from America was the more modern way. Moreover, the idea of walking a mile from a rice field to urinate in a hole in order to prevent schistosomiasis was completely unrealistic. From this experience, I learned to ask parents about their own goals for their lives, to understand their individual circumstances and barriers, and to explore the reasons for their decisions. Moreover, a wise, African physician, son of the local chief, helped me understand the importance of respecting culture, community involvement, and being collaborative while integrating modern medicine and concepts alongside traditional approaches. He had set up a local board of 20 chiefs from nearby villages who would send out messages with some of my recommendations about healthy life style concepts, including the value of breast feeding, via drums (a precursor to emails).

Traditional African shamans were always included in helping treat patients alongside modern medicine. It became clear to me that the motivation for behavior change comes about not as a result of being told by others what to do, but from a collaborative, experiential, and culturally sensitive relationship amongst families, communities, and clinicians.

My subsequent Yale graduate school experiences-while becoming a pediatric nurse-practitioner (**PNP**) and obtaining a degree in public health-included a master's thesis for which I evaluated delivery of modern medicine to the Cree and Ojibwa First Nation people. I conducted this research while working as a nurse on an island in Hudson Bay, Ontario. The only non-native person on the island, I found that pregnant mothers were hiding for fear of being sent south by plane to deliver their babies in hospital. They preferred to have their babies in their own tents with familiar women around them; they were terrified of modern delivery rooms and the method of delivering babies with their legs held up in the air with stirrups. Subsequently I received a summer grant to interview Navajo women about their parenting methods and, post graduation, I worked for pediatricians offering parent groups and helping parents manage their children's behavior problems. After my marriage to a physician, we moved to Alaska where I worked for two years as a PNP with Tlingit, Haida, and Tsimshian people. Part of the time I was known as the "toy library lady" bringing in different toys on home visits to teach parents how to stimulate child development through play. I became convinced that "talking therapy" alone was not enough for parent behavior to change; I felt that change needed to be experiential, collaborative, culturally sensitive, and supported by a strong and trusting relationship with the clinician.

Dr. Kate Kogan was my third important mentor during my graduate doctoral studies in educational psychology. She had been trained by Connie Hanf (1973) to use the "bug-in-the ear" video feedback and coaching methods with parents who had children with developmental delays. The "bug in the ear" method I learned included giving feedback to parents using edited videotapes of their interactions with their children. This was followed by asking parents to wear a small hearing aid while playing with their children. During my observations of this play time through a one-way mirror, I could give the parent in-the-moment clinical advice. For example, I could suggest replacing critical responses with positive responses, ignoring inappropriate behavior, and describing the child's actions rather than asking questions. Dr. Kogan's research outcomes with children who had developmental delays were compelling (Kogan & Gordon, 1975).

My volunteer work with Dr. Kogan re-ignited my earlier photographic passion. I was convinced that videotape and performance methods could be a more valuable therapeutic and teaching tool than the typical verbal cognitive approaches. I vividly recall the very first parent I worked with using video feedback. After showing her edited tape of her interactions with her child she started to cry. She said, "I have always seen my mother as very critical

but have never seen the same behavior in myself." Seeing the video of herself set the stage for a self-reflective process of emotional release and behavior change. While I was entranced with the idea of using video feedback and bug-in-the ear coaching methods as a therapeutic tool with families, I realized that this personalized method was costly and time consuming, involving hours of editing, and would not meet the needs of the increasing numbers of parents wanting help managing their children's misbehaviors. I wondered if parents in a group format could learn from watching standardized videotape vignettes of other parents managing common behavior problems. There was considerable skepticism and disbelief that this group-based and collaborative parent approach-without the individualized bug-in-the-ear coached parent-child play sessions-would work to change parent behavior. Moreover, in the 1970s, most people thought I would never be able bring about change with this rarely used videotape modeling method!

To test my idea, for my doctoral research I developed a standardized video-based parent program with excerpts from the videos I had filmed from my bug-in-the-ear parent experiences. With this four-week, two-hour session program I conducted my first randomized control group study to evaluate the effectiveness of such an approach for improving parent-child interactions and reducing behavior problems. I hypothesized the parents would learn more through standardized videotape modeling, group discussion, peer support, and home practices with their children than from the more verbal-based one-on-one approach, which was considered the "gold standard" of parent training at that time. I believed that offering the program in the form of video vignettes designed to trigger self-reflection, group problem solving, and practices would be more cost effective and would provide often isolated and stigmatized parents with much needed support. I recruited parents of young children (ages three to six years) exhibiting disruptive behavior problems with the following short term goals: improve parent-child relationships, replace harsh discipline with proactive discipline, improve parent-teacher partnerships, and increase parent support. I hypothesized that targeting these parenting changes when children were young would lead to improved children's social competence, emotional regulation, school readiness, and prevention of social and emotional problems. The long-term goals were to prevent the development of conduct disorders, peer rejection, academic failure, delinquency, and substance use through the mechanism of teaching early effective parenting practices.

Creating Content

The basic parent content that was the underpinning of the video vignettes I developed for the first Incredible Years parent programs was based on the research and theory of the giants in the field of the 1970s. Gerald Patterson's work, including cognitive social learning theories about the development of antisocial behaviors in children (Patterson, Reid, & Dishion, 1992) was

fundamental. His theory of change focused on interrupting negative, coercive parent-child cycles by teaching parents proactive discipline methods. The content that I developed related to children's developmental milestones was derived from Piaget's developmental cognitive stages and interactive learning methods (Piaget & Inhelder, 1962). The impetus for developing content aimed at building positive parent-child relationships was based on attachment theories (Ainsworth, 1974; Bowlby, 1980). A focus on building positive emotional relationships was not included at the time in standard behaviorally-focused parent training approaches. Finally, the basis of the cognitive strategies for challenging parent's angry and depressive self-talk, and the importance of developing support systems, came from Beck's research (1979) amongst others. I was lucky to be able to build on the shoulders of these amazing theoretical giants. I call this one of the serendipity factors in my professional development.

My first step was to take my theoretical understanding and put the IY content framework and sequence together. At the time there was some belief that parents should begin training by learning discipline (aka punishment) to manage their children's aggressive behavior because this was parents' primary goal. However, based on my earlier experiences, I felt that encouraging more positive parent-child interactions and relationships would be the necessary foundation for eventual behavior change. From Hanf's child-directed play concepts and my prior play therapy experiences, I developed a parent coaching technique known as "descriptive commenting", in which a parent describes a child's actions in real time-as if to a person who could not see the child. I taught parents to describe the specific positive behaviors that children displayed while playing, based on developmentally appropriate child behavior goals previously agreed upon with the parent. My theory was that this descriptive or narrated commenting was like enfolding the child in a warm, non-intrusive blanket of language that provided support to the child's play, showed the child that the parent was interested in them, and enhanced their language by linking words with the actual objects or actions. When children had language delays, parents focused on simple vocabulary words to expand children's language repertoire. When children had social skills deficits or difficulties with emotion regulation, parents described times when children were using positive social skills or were demonstrating regulation.

Over time I expanded descriptive commenting to include two other types of coaching that I called "social coaching" and "emotion coaching." Social coaching includes using descriptive language for the child's social behaviors: "You just shared those blocks with your sister," and emotion coaching includes describing the child's feelings, "You look so proud of your picture. I saw that you worked hard on it!" "Your sister looks happy that you shared with her." These two coaching methods extend beyond simple descriptive commenting and involve teaching parents to model and prompt social behaviors and

emotional states in a non-directive way. Social and emotion modeling examples by the parent include: 'I'm going to be your friend and share my cars with you.' Or, 'I'm feeling frustrated, but I'm going to take a deep breath and try again to put the puzzle together.' Parent prompting children examples include: "If you want a turn, you can say: 'can I have a turn, please?'" or "I can see that you're angry. I bet you can stay calm and take a deep breath."

A few years later, after working with children with **ADHD** (about 40% of our sample of children with Oppositional Defiant Disorder also had elevated **ADHD** symptoms), I expanded the coaching methods further to include "persistence coaching." This approach was an effort to help parents understand how they could promote children's focus and ability to persist, stay calm and self-regulate when distracted or frustrated or bored. Parent persistent coaching examples include: "That's a hard problem, but you are really sticking with it." Or, "I can see that didn't work the first time you tried it, but you are staying patient and trying again to figure it out. I think you are going to figure it out."

With the addition of these highly refined coaching approaches, plus the addition of common strategies such as praise and rewards, my original four-session program designed for my dissertation expanded to a parent training course of nine two-hour sessions to cover this coaching based material. Today this child-directed and coaching material comprises the first 50% of the Incredible Years Basic Parent Program content. It seemed clear from the weekly session parent evaluations and initial outcomes that this foundational coaching and relationship work strengthened children's positive behaviors and self-regulation skills, replacing inappropriate, impulsive behaviors, reduced parents' use of negative or critical parenting, and enhanced parent-child attachment.

In subsequent years, I integrated my experience with fantasy play utilizing pretend characters and puppets within the coaching strategies, which led to even greater parent-child positive engagement. For example, a parent using a puppet could share with the child during play his feelings of sadness that his dog died, or disappointment his friend wouldn't play with him, or happiness he was learning to read in order to open up the opportunity for the child to talk about similar feelings. In some cases, children's conduct problems are a manifestation of single or multiple traumatic family life experiences. Parents' use of puppets or pretend characters to address trauma themes or life events similar to what their children may have experienced is a way to open up difficult communication. This tailoring lead to a trauma-informed approach to delivering the programs for particular populations.

Contrary to some parent programs available in the 1980s, I felt it was not necessary for parents to achieve "mastery" in the coaching methods or praise before moving on to strategies for directly decreasing negative child behaviors. The foundational relationship principles were continually referred to and strengthened further in subsequent sessions as part of the collaborative learning process.

The second half of the parent program content was focused on establishing consistent household rules, effective limit setting, and appropriate responses to misbehaviors. It was apparent from our interviews with parents that often they had no clear routines or rules and limits were either non-existent (permissive) or overly coercive and controlling (authoritarian). Based on the work of Baumrind on *authoritative parenting* (1966) and Patterson's "coercive theory" (1992), I felt it was important to help parents understand how to achieve a balance of clear and simple household rules and routines alongside nurturing and empathic responsiveness before teaching respectful discipline methods. I added strategies to manage misbehavior starting with the least intrusive methods such as distraction, redirection, and a planned ignoring approach.

I first learned about a "Time Out" procedure at a parent training workshop in the 1980s. That approach taught parents how to keep children who would not stay in Time Out by hitting them with a two-inch dowel rod. However, my Time Out approach was taught not as a punishment, nor were children ever restrained in Time Out, but instead was used as a respectful way to teach children how to calm down and self-regulate as well as to remove reinforcing (if negative) parent attention. Time Out was only used for children over the age of three and often required tailoring for children with developmental delays, ADHD, or with poor attachment with their caregiver. Children's developmental ability to understand and use the TO procedure is considered, as well as the importance of a foundational nurturing relationship as a basis for using Time Out.

Time Out was further refined to have children learn and practice how to take a Time Out to calm down before parents actually used it. This refinement came about after visiting a friend who wanted help disciplining her three boys who were constantly fighting. I was showing her the Time Out video vignettes and her boys came in and asked to watch. This resulted in a family discussion at a time when they were calm and receptive, followed by a spontaneous practice using Time Out to calm down. Later, when one of the boys hit his brother and was sent to Time Out, he went without resistance. I was convinced this worked well because of the prior teaching and practice of the procedure with the children. Subsequent to this unplanned personal experience, I incorporated teaching children how to take a Time Out to calm down as a standard part of our Time Out training for parents, teachers, and children. I developed new vignettes showing how parents can explain Time Out to calm down to their children (at times when they were calm) and then how to practice this with them using positive self-talk, deep breathing, positive imagery, and puppet practice.

The decision to incorporate beginning problem solving skills as the last program component for preschool and school age children (not for toddlers) was made to be sure that parents first had developed a positive relationship with their child as well as confidence in their limit setting and discipline

approaches. When this is in place, children will already have developed some positive social skills and emotion management strategies so as to be able to engage in problem solving discussions and come up with possible appropriate solutions.

A decade later after delivering and researching the Child Dinosaur Curriculum, which heavily relied on therapists' use of large, child-size puppets (Wally Problem Solver), we began to incorporate more teaching of parents in how to use puppets, imaginary toy characters, and pretend play to model social skills such as helping, sharing, taking turns, waiting, and complimenting, to demonstrate empathy and emotional language, as well as how to use puppets to teach children calm down and problem solving strategies. Parents learned to use puppets to help children talk about feelings, practice self-regulation strategies such as deep breathing, positive imagery, positive self-talk, muscle relaxation, and managing traumatic situations. Even older children, who understand that puppets are not real, are still motivated to engage in this imaginary phase of cognitive development and enjoy playing being "detectives" and role-playing solutions to the drama stories involving hypothetical problems. About 10 years ago, I worked with a boy in our ADHD study who also had autism and had to be taken out of the child group because he was overstimulated by the noise and hyperactivity in the room. Interacting with this boy one-on-one with my Wally puppet helped me to discover that he had much more language, empathy, and social skills than I ever had observed in the child group. This convinced me of the importance of training parents in using puppets to connect with their children who had autism spectrum diagnoses as well as behavioral problems and ADHD. In fact, our recent work in the past three to four years with the autism parent program has resulted in expanding our BASIC program to include not only more puppet use and pretend play but also increased use of songs, nonverbal gestures, games, and visual prompts.

After I had my own children, I personally realized the impact of emotions and cognitions on parenting skills. There were times when I intellectually knew I should ignore my child's misbehavior but could not because of my emotional response and negative thoughts. Through my work with parents of children with conduct problems and ADHD, I became aware that content about appropriate parenting skills was necessary but not sufficient. Parents of these children were experiencing stress, marital discord, depression, isolation, poverty, trauma, and interpersonal problems that interfered with their ability to parent effectively. Almost a decade after developing the **BASIC IY** program, I developed the Advance program to address some of these additional risk factors, which as a supplement to the **BASIC** program led to significant improvements in parent and children's problem solving abilities (Webster-Stratton, 1994) and became one of the essential components of our treatment protocols for children with conduct problems and ADHD.

Video Vignette Development

The truth is that I developed the idea for a group video-based program from personal experiences, intuition, and a passion for photography, and subsequently searched for theories that would validate my methodological approach. Fortunately, the rationale for the collaborative, modeling, and self-reflective therapy methods I proposed could be found in Bandura's modeling and self-efficacy theory (Bandura, 1977, 1982). I designed the vignettes to trigger group reflective discussions, problem-solving, exploration of emotional and cognitive barriers, and coached practice. I discovered that video vignettes of parent-child interactions helped to normalize common parent traps, de-stigmatize a parent's sense of failure, and help parents be more empathic to children's individual viewpoints, developmental trajectories, and temperaments.

I began developing the child-directed play video materials in 1980 by filming hundreds of hours of parents and preschool children playing together. Originally I built a mock kitchen and living room studio set and filmed parents playing with their children with a series of toys I provided. There were no planned scripts as I understood from the theory of modeling that parents would be more likely to model parents who they perceived as natural, unrehearsed, and similar to themselves. I spent thousands of hours examining these tapes to find the 30-second to one-minute vignettes that illustrated a point about responsive, child-directed play. Here intuition and my gut reaction eventually determined my choice of over 300 video segments for the first parent program. I would describe this process as a bit like searching for love: You cannot exactly define what you are looking for, but you know it when you see it. Originally my programs had contrasting examples of effective and ineffective vignettes of parent-child interactions, but gradually I edited out many of the ineffective parent-child interaction strategies. I learned that the negative examples had a powerful and often dysregulating effect on parents, and were always the vignettes parents remembered the best. I wanted parents to have images of calm, patient, and loving parent-child interactions and not of yelling or criticizing children. Currently the more negative or less effective parent-child parenting vignettes in the programs are set up to allow parents to share and practice how to improve upon the interactions and to be compassionate toward the parent models.

In later years when our large expensive cameras with fourteen-inch reels of two-inch wide quad videotape film (\$300 per one hour reel in 1980s dollars) became smaller, easier to use, and less expensive with the digital revolution, I was able to move the filming into parents' homes so that I could get more natural examples. For some programs I also was the second camera person who focused on close-ups while the professional would get the wide shots. I frequently knew where the camera should be before the professional did. In recent years, I added vignettes of parents or teachers talking about their

experiences participating in the IY program, which helped forecast participants' success if they continued to use the program strategies.

Once I had put together a set of vignettes that demonstrated a specific concept such as emotion coaching, I then wrote narrations to precede each set of vignettes. The narrations reviewed the main developmental, emotional, or behavioral principle and primed the parents on what to watch for. I also felt a summary narration would assure that the information parents got was accurate and clear, and would prevent groups or IY group leaders going off on tangents. In the leader manual I also suggested open-ended leader questions to keep the discussion focused on the key learning principles for participants to discover and subsequently apply to their individual goals.

IY Processes and Methods Development

Once I developed the vignettes and key content, my next learning process focused on how clinicians could effectively utilize these vignettes to build on parent strengths by inviting safe discussion, reflection, problem solving, discovery of key principles, and setting up parents' individualized practice. In other words, what were the important clinical methods and processes underlying fidelity delivery of a video-based program? This included how many vignettes should be shown in one two-hour session; how much time should be spent on video versus live modeling, and on cognitive discussions versus practice exercises; how group leaders should handle parents' resistance to new concepts; and how often a clinician should pause a video vignette to foster parent group discussions, self-reflection or trigger a practice exercise. What is the correct program dosage and how will the intervention protocols be different for prevention intervention versus treatment for children with diagnoses or higher risk populations? How collaborative or prescriptive should the clinician leadership style be? When would confrontation or direct teaching be useful? How much attention should be given to changing parents' thoughts and emotions or discussing past experiences versus targeted behaviors and future goals? How can the group leader ensure training is culturally sensitive? How are individual family needs and goals addressed alongside overall group process and learning? What adaptations are made to the program for less educated parents, parents from different cultural backgrounds, or children with different developmental issues?

It became clear to me in watching hundreds of video hours of different group leaders delivering the program over many years that, in addition to group leaders having adequate social learning and child development knowledge, group leader relational characteristics (affect, warmth, humor, support, leadership) and therapeutic and collaborative skills to promote the parent discovery process were key determinants of positive parent outcomes.

Each parent session starts with a "benefits-barriers" exercise in which parents discuss perceived positive reactions to the home activity or the new topic

of the day (for example, praise or ignoring), as well as any personal challenges or barriers that might get in the way of implementing the new skill. The discussions use a problem solving format: identifying the problem, identifying an alternative "positive opposite" behavior, practicing possible solutions, and reviewing barriers and how to overcome them. I believe these IY methods and processes are key to participants' ability to make meaningful changes. This understanding led to my writing a book for therapists about the collaborative process (2012).

How Research Affected Incredible Years Ongoing Program Development

Throughout my 35-year career at the university clinic, I continued to offer IY parent groups on a regular basis in the context of NIH-randomized control trials. Weekly session evaluations from parents, and video reviews of our sessions, as well as outcome data meant that I could find out what worked or did not work in comparison to wait-list control families. For example, one of my first studies focused on the value of using a video-based modeling group approach compared with the more personalized bug-in-the-ear approach. Once this research revealed that the video-based modeling group approach was as good as the one-on-one approach at post test, but provided more social support, was more cost efficient, and actually resulted in more sustained results at one-year follow-up (Webster-Stratton, 1984), I became committed to the group model as a core therapeutic IY approach.

Refining and Expanding

After 15 years of research exploring the best methods of training parents, it became clear that while the IY Parent programs could impact children's behavior at home, these changes at home did not necessarily generalize to classrooms or with peers. Consequently, the IY Teacher Classroom Management and Child Dinosaur programs were developed to see if the addition of one or both of these programs could bring about more sustained changes in children's behaviors across settings (<http://www.incredibleyears.com/research-library/>).

Over three decades of research, The Incredible Years Series has become a system of interlocking interventions that use similar cognitive, emotional, and behavioral clinical methods to include parents, teachers, and children. All focus on the same key outcomes, but act through different channels and with different developmental foci. All of the programs include the following methods: video and live modeling, group discussion and problem solving, short- and long-term goal setting, experiential practice exercises in the group and at home or in the classroom, promoting cognitive and emotional self-regulation and self-care, and building support networks. This learning occurs in a collaborative, reflective, and supportive atmosphere where teachers,

parents, and children are encouraged to "discover" the solutions and builds on their strengths and experiences. The programs can be used independently, but research suggests that for diagnosed children and high-risk families, the effects are additive when used in combination. Each of the programs is thematically consistent, includes the same theoretical underpinnings, and is based on the developmental milestones for each age stage. There are a minimum number of sessions required but clinicians are encouraged to expand on the number of sessions according to group needs and background. The treatment protocols are longer than the prevention protocols in order to allow more time for individualization, enhanced practices, and showing more vignettes.

New DVDs, USBs and now some streaming of videos as well as group leader manuals have continued to be refined and created for different populations. For example, the parent program now has four different versions for distinct developmental ages from infants to preteens; I also developed a shorter, universal parent program designed for all parents of children of two to six years (Attentive Parenting), a program for day care providers and preschool teachers working with younger children (one to two and three to five years) (Incredible Beginnings), and two new programs for parents and teachers working with young children on the autism spectrum (two to five years).

Making the Decision to Disseminate ~ Challenges and Successes

Eighteen years after publication of my first study with the parent program and many positive randomized control group studies (Menting, 2013), requests began to come in for information about obtaining program materials and training possibilities. Largely these requests came from individuals in countries such as the UK, Norway, Denmark, New Zealand, and the Netherlands who had reviewed the research evidence and were interested in both evaluation of the program and dissemination in their own country, as well as researching their effectiveness for use in their population. I began an independent business to disseminate the programs. Because I had originally funded the filming, editing, and video production program costs with personal funds and not as a university employee, I retained full ownership, copyright, and trademark for the IY program. A contract with the university acknowledged this ownership, permitted me to use the programs for training and grant research, and stipulated that all further work related to marketing, training, and further product development would be done outside of the university. Until my retirement in 2011, I submitted financial disclosure forms yearly and participated in ongoing reviews regarding potential conflict of interest. A few years later, I decided to give up half my tenure salary and reduce my time at the university, spending the other half of my time engaged in disseminating the Incredible Years programs.

Having spent three decades as the developer of the Incredible Years series researching and expanding clinician manuals, video vignettes and protocols, I

believed we had the tools to begin dissemination with fidelity. At that time, it was unclear to me whether clinicians would even need training because I believed everything was clearly articulated in the materials. However, I quickly learned from my video reviews of clinician group sessions that neither the materials nor brief workshops alone were sufficient to promote fidelity delivery. Clinicians needed help understanding how to tailor the discussions and learning to parents' and teachers' settings, goals, and cultural context as well as children's development level and diagnoses. A study of IY fidelity processes and strategies revealed the added benefits of ongoing coaching and support for clinicians as well as training agency administrators to support their group leaders (Webster-Stratton, Reid, & Marsenich, 2014). When I retired from the university, I pursued the dissemination journey in more depth by providing quality training, consultation, and ongoing support by certified coaches, mentors, and trainers, and promoting fidelity delivery of the programs through the certification/accreditation process.

Lessons Learned

As the developer of an evidence-based program (EBP), I did not understand that I would need to do more than develop the content and general procedures for program delivery and show positive research results. That was perhaps the easiest part. I found it was also necessary to develop a comprehensive training process, including ongoing support and consultation for the group leaders as well as for the administrators. The metaphor I use for developing and scaling up an EBP is building a house where there must be an architect (program developer) who takes advantage of changing technology and collaborates with the family or teacher around their needs and goals; a committed contractor who monitors building quality (agency or school administrator); onsite project managers to support and train staff (mentors and coaches); and a well-trained team of construction workers (group leaders). If there are problems in any of these links the building will not be sound. For example, when there are agency and clinician barriers, it is as if the contractors, hired electricians, and plumbers who were not certified, disregarded the architectural plan, and used poor quality, cheap materials. The Incredible Years Program Training Series has been set up with a supportive infrastructure of eight building blocks designed to promote program fidelity (Webster-Stratton & McCoy, 2015). The IY Series is now widely used in 18 countries; there are 8 accredited trainers, 75 mentors, and 110 peer coaches providing training and support to IY group leaders.

Lessons Learned and Next Steps

My experience has taught me that EBP development must be thought of as an ongoing building process rather than an endpoint. An important implication

for prevention and dissemination science is understanding that effective programs continue to evolve and improve based on internal evaluation audits and feedback. As a parallel, consider that the safety features of cars continuously improve. Few people, when given the option, would opt to drive the old model without the proven safety additions. Gathering data on what works, eliciting ongoing feedback, and actively participating in the implementation of the intervention across a variety of contexts provides the needed information to improve interventions and meet the needs of culturally diverse populations.

Agencies charged with improving the well-being of children and families now have good options for selecting EBPs that are grounded in an extensive research base. The field has learned much about the necessary ingredients for successfully transporting efficacious practices into real world settings with diverse cultural populations. Some of the critical factors include selecting optimal clinicians, providing them with quality training workshops coupled with ongoing supportive mentoring and consultation, and ongoing program evaluation and monitoring of program fidelity.

It has also become clear to me that successful development and implementation of evidence-based programs requires a serious sustained commitment of personnel and resources. After almost four decades of working at providing research evidence to justify the use of these programs, I can see that bringing about change in parent, teacher, or organizational behaviors requires a committed, persistent, and collaborative team who believe change is possible. Moreover, I have also learned that technology such as video is an important adjunct tool but not sufficient in itself because, in the end, as I learned years ago in Africa, it is the ongoing relationship building that is the key to bringing about innovative change. My mother used to complain that I was always trying to change things. While that is true, I will tell you that I have had fun doing this, and seeing the positive changes in children, and their relationships with their parents and teachers makes it well worth the effort.

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