Innovation of Incredible Years: Where we have been and where do we go from here?

Carolyn Webster-Stratton, M.S.N., M. P.H., Ph.D.

Draft not for distribution

Chapter for book Designing Effective Prevention and Public Health Programs: Expert Program Developers Explain the Science and the Art edited by Mark Feinberg.

The Incredible Years (IY) Series developer reviews the rationale and theories underlying the framework structure, content, methods, processes and rationale for the development of the Incredible Years Parent, Teacher and Child Programs. She discusses her early personal and professional experiences leading to her passion to develop, evaluate and continue to refine cost-effective, group-based video-based intervention programs for supporting parents of young children (birth to 12 years) in parenting strategies that strengthen their children's social, emotional, language and academic development as well as prevent child abuse and neglect and treat child conduct problems. Based on the first decade of her research and experiential lessons learned from working with parents she takes this learning further to develop and evaluate new video-based programs for training teachers and children in order to expand the impact and breadth of outcomes to a variety of populations such as children with conduct and internalizing problems, ADHD, developmental delays and autism as well as higher risk populations due to poverty and new immigrant status. Once the evidence based for these programs had been established she then explores a parallel training process of using group-based video modeling, role play practice and experiential learning, support and collaborative methods for training and certifying IY clinicians, coaches and mentors and ensuring that the programs are delivered with fidelity within agencies.

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 research career?" 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 both as a camper and then as a counselor. Modeling theory would also suggest that I was motivated to try to bring about positive change in children's lives in part because my father was a model mentor for innovation, 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 women 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 am told by my parents that even as a baby I was fascinated by observing people as apparently my favorite activity was being tied up on 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

still love sharing my picture heaving 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 assess clinician intervention sessions and trainer workshop effectiveness. My early experiences working in a dark room with film progressed to reproduction of digital pictures via the computer and taught me to expect change and to learn from it.

Several key mentors in my early 20's 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 was for me was to train local people with at least 3rd grade education to help pregnant women eat healthier food and to breast feed rather than bottle feed. While teaching women to eat more nutritious foods to increase their babies' healthy 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 seemed like magic to the African people as they had not previously seen what photographic images came from cameras, so while my teaching efforts didn't change behavior it did provide good entertainment. Before long I learned that the reason that these mothers didn't eat much during pregnancy was because they would have big babies that they could not deliver due to Rickets and flattened pelvises. This in turn lead to serious tears and fistulas that could not be surgically fixed. I also learned that mothers bottle fed rather than breast fed because powdered milk was being sent to them from America and they believed it was the more modern way. Moreover, the idea of walking a mile from a rice field to urinate in a hole was completely unrealistic. From this experience, I learned to ask parents about

their own goals for their lives, to understand their individual circumstances, and to explore the reasons for their decisions. Moreover, this wise, African physician mentor whose father was the local paramount 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 paramount chiefs from nearby villages who would send out via drums (a precursor to emails) some of my recommendations about healthy life style concepts, including the value of breast feeding. 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 telling others what to do, but from a collaborative, experiential, and culturally sensitive relationship between families, communities and clinicians.

My subsequent Yale graduate school experiences while becoming a pediatric nurse-practitioner (PNP) and obtaining a degree in public health involved a master's theses where I evaluated delivery of modern medicine to the Cree and Ojibwa First Nation people living on an island in Hudson Bay, Ontario. As the only non-native person on the island, I found pregnant mothers 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 women around them and were terrified of modern delivery rooms and the method of delivering babies with their legs in the air. I met a Cree man who having had polio and given leg braces had discarded them due to their weight and difficulty geting into his canoe. Again it seemed modern methods were being imposed without understanding the culture and values of the families. Subsequently I received a summer grant to interview Navajo women about their parenting methods and for two years as a PNP with Tlingit, Haida, and Tsimshian people in Alaska. Part of the time I was 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. Her research outcomes were compelling (Kogan & Gordon, 1975). My voluntary work with her re-ignited my earlier photographic passion. I was convinced that videotape and performance methods could be a more valuable therapeutic and teaching tool than verbal cognitive approaches. I recall vividly the very first parent I worked with having a dramatic effect on me. 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 emotion 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 wouldn't meet the needs of increasing numbers of parents wanting help managing their children's misbehaviors. I wondered if parents could learn from watching standardized videotape vignettes of other parents managing common behavior problems and whether this learning could happen in a group format. There was considerable skepticism and disbelief that this more impersonal group and collaborative parent approach without individualized parent-child play coaching would work to change parent behavior. To test this idea, for my doctoral study research I developed a standardized video-

based parent program based on the videos I had filmed from my bug-in-the-ear parent experiences. With this 4 week, 2-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 videotape modeling, group discussion and home practices with their children than from verbal-based lecture approaches, which were common 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. The program initially targeted parents of young children (ages 3 to 6 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 abuse.

Creating Content

The basic parent content that was the underpinning of the video vignettes I developed for the first Incredible Years parent programs came from the research of theoretical giants of the 1970's including cognitive social learning theories about the development of antisocial behaviors in children (Patterson, Reid, & Dishion, 1992). Their theory of change focused on breaking the negative, coercive parent-child cycle by teaching parents proactive discipline methods. The parent content related to different children's developmental milestones was derived from

Piaget's developmental cognitive stages and interactive learning methods (Piaget & Inhelder, 1962). The impetus for developing content related to building positive parent-child relationships came from attachment theories such as Ainsworth and Bowlby (Ainsworth, 1974; Bowlby, 1980). Finally, the cognitive strategies for challenging angry and depressive self-talk, and the importance of developing support systems came from Beck's research (1979) amongst others.

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 content related to coaching language known as *descriptive commenting* that involved describing children's actions as if to a person who could not see the child. Based on subsequent studies and my experiences with parents and children with conduct problems who had language delays, emotional regulation difficulties and social skills deficits who targeted the specified positive child behaviors they wanted to see more of, I expanded this descriptive commenting to include 2 other types of coaching known as *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!" These two coaching methods also include 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 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 diagnoses of Oppositional Defiant disorder also had ADHD symptoms), I expanded the coaching methods further to include *persistence coaching* in 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."* These highly refined child-directed coaching approaches plus the addition of commonly used strategies such as labeled praise and rewards morphed from an original 2 session dissertation project on this topic to nine 2-hour sessions. Today this comprises the first 50% of the Incredible Years Basic Parent Program content. It seemed clear from the weekly session parent evaluations and initial research outcomes that this foundational coaching and relationship work strengthened many of the children's positive behaviors and self-regulation skills that served to replace their inappropriate, impulsive behaviors and resulted in more positive child outcomes. This positive attention, in turn, rewarded the children's continued use of these positive approaches, reduced parents' use of negative or critical parenting and enhanced parent-child attachment. In subsequent years using these coaching methods with new immigrant families and other cultural groups, the descriptive commenting and coaching methods were expanded further to assure that ELL parents understood that they could describe and coach adding a second language to assist children with bilingualism. Moreover, I found that children often shared more when their parents

spoke their own language and when they engaged in fantasy play utilizing pretend characters and puppets than when they would share without a puppet. This resulted in expanding training so that parents understood the importance of pretend play and using puppets or toy characters to model and prompt social, emotion and persistence strategies. 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. Since many childrens' conduct problems are a manifestation of single or multiple traumatic family life experiences, the parents use of puppets or pretend characters to bring up common trauma themes or life events similar to what their children may have experienced was a way to open up difficult communication between them at a safe and relaxed time.

Contrary to some parent programs available at the time I felt it was not necessary for parents to achieve mastery in the coaching or praise concepts before moving on to the content related to decreasing child behaviors parents wanted to see less of as these foundational relationship principles were always referred to and strengthened in subsequent sessions as part of the collaborative learning process. I remember saying frequently, "*we never master parenting, but keep learning ourselves and adjust as our children develop new skills or new problems*". The 2nd 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 homes 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's *authoritative parenting* (1966) I felt it was important to help parents understand how to achieve a balance of power with clear and simple household rules, developmentally

appropriate limits and regular routines along side respectful, nurturing and empathic responses before using discipline methods. This parent goal in itself often resulted in improved child behavior. Next I added content strategies to manage misbehavior starting with the least intrusive methods such as distraction, redirection, and planned ignoring for toddlers followed by similar approaches plus some other consequences for preschoolers and school age children. I first learned about a Time Out procedure at an APA parent training workshop in the 80's. This approach taught parents how to keep children who wouldn't stay in Time Out by hitting them with a 2-inch dowel rod. However, intuition, modeling and attachment relationship theory convinced me this was not a method I wanted to employ in this way. Instead my Time Out approach was taught not as a punishment, nor were children ever restrained in Time Out but this method was used as a respectful way to teach children how to calm down as well as to remove parent attention which may have been reinforcing their negative behaviors. This approach was only used for children over age three and usually tailored for children with developmental delays such as children with ADHD or with poor attachment with their caregiver because of prior trauma until the foundational nurturing relationship was firm. This approach was further refined to have children learn and practice how to take a Time Out to calm down before parents actually used it. This Time Out refinement came about after visiting a friend who wanted help disciplining her 3 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 to this information followed by a practice with them in using Time Out to calm down. Since they were sports fanatics the idea of Time Out appealed to them. Later on that weekend visit 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 and imagery. Parents also learned to use a turtle puppet to explain to children how to use "turtle power by withdrawing into their shell and coming down before trying again to solve a problem. Later when the Incredible Years Child Dinosaur program was developed and children practiced Time Out in the first child group sessions, I found that this approach enhanced not only therapists' success with the approach with children but also parents in the parent group reported being more successful using this method at home. In a recent doctoral dissertation (Houlihan, 2013) of the IY child program when children were interviewed they said they found Time Out was a safe place to calm down and then try again. In our clinic often parents would tell us that their children actually reminded them of the rules for taking Time Out.

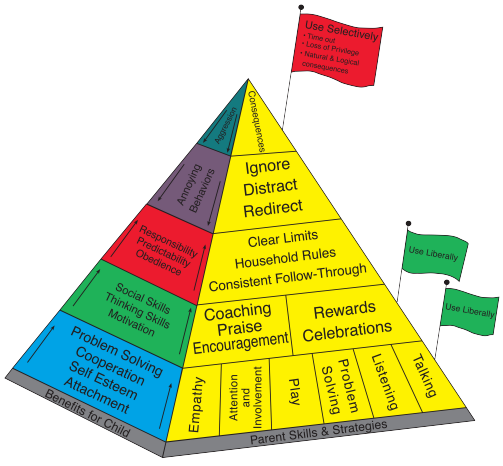
The decision to incorporate beginning problem solving skills as the last content training component for preschool and school age children (not for toddlers) was made to be sure that parents first had developed a positive relationship with their child as well as confidence in their limit setting and discipline 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) to help with the teaching of children, 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, and complimenting and well as to demonstrate empathy and emotional language, as well as how to use puppets to teach children 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. I developed a series of children's books called *Wally's Detective Books for Solving Problems at Home and at School* (e.g., death of a cat, feeling blamed or left out, lying, reacting to mother's crying, being afraid of staying overnight, fear of dad's anger, losing something etc.). These books presented many common child problem scenarios at home and at school and prompted parents and children to talk about how to solve the problems. After parents read a problem scenario to the child and discussed possible solutions, then using puppets together they practiced acting out possible solutions. After engaging in this fun play activity they can look to the back of the book and see what solutions Wally (one of our puppets) came up with. I recall using Molly Manners, a puppet in Dinosaur School who strategically shared a problem one of the children in the group had, that she had stolen her friend's Barbie doll and needed help solving the problem. The girl in the group responded by saying, "I once had that problem" and then taught Molly how she could be honest with her friend and demonstrated how she would confess and apologize. This approach of using puppets to share problems that mirror children's lives and then encouraging children to help the puppets to find and practice solutions is a powerful method of engaging children in learning problem solving methods, dealing with stressful experiences and developing language skills as they develop their own story solutions. Even for children past the the preoperational stage of cognitive development (3-6 years), who understand that puppets aren't real are still motivated to engage in this imaginary phase of cognitive development enjoy

playing being "detectives" and role playing solutions to the hypothetical problems. Moreover, engaging in a child's imaginary world creates an intimate bond and a high level of trust between the parent and child. About ten years ago I recall a boy in our ADHD study who also had Autism who had to be taken out of the child group because he was overstimulated by the noise and hyperactivity in the room. I worked with him individually with my Wally puppet and discovered he had much more language, empathy and social skills than I ever had observed in the child group. This convinced me of the importance for training parents in using puppets not only for children on the autism spectrum but also for children with behavioral problems. In fact, our recent work in the past 3- 4 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 use of songs, more nonverbal gestures, games and visual prompts. This is especially emphasized in the treatment protocol and for higher risk populations.

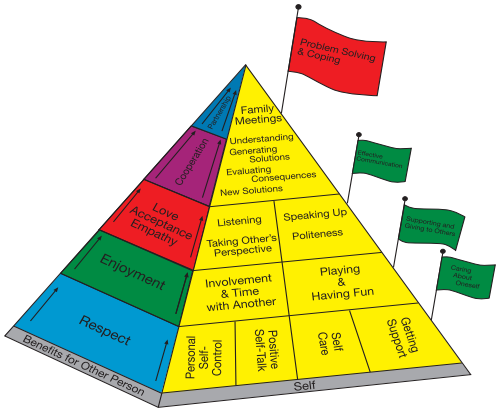
This content sequence, first developed in 1980 but used in a less complex way in my doctoral dissertation, formed the essential elements and sequence of the Incredible Years parenting pyramid content (see parent pyramid) to become the bedrock of the current Incredible Years Parent Program as well as the IY teacher and child programs which are based on the same principles taught to different audiences. See review paper for this research on the BASIC program (Menting, Orobio de Castro, & Matthys, 2013) .



Parenting Pyramid®

The Incredible Years

Through my work with parents of children with conduct problems and ADHD, I became aware that content about parenting 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 in calm and consistent ways. Almost a decade after developing the BASIC IY program, I developed the Advance program to address some of these additional risk factors with content focused on adult interpersonal factors such as cognitive stress and depression management, anger management, problem solving for parents and with teachers, building support networks, and teaching children to problem solve and to use self-regulation skills. Interestingly this program was developed after I had my own children and personally realized the impact of emotions 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. Our research showed that the addition of the Advance program 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. Moreover, the trauma informed elements of Advance content began to be integrated into my revised versions of the BASIC treatment program manual including practice and buzz assignments regarding parent affect regulation and cognitive coping methods such as self-praise and rewards for achieving short term goals, positive self-talk, challenging negative



Pyramid for Building Relationships

self-talk, focused deep breathing, positive imagery and self-care. This parent approach was consistent modeling with the way we were teaching parents to use Time Out as a method for children to learn to calm down and self-regulate as well as for themselves.

Video Vignette Development

The truth is that I developed the idea for a group video-based program from personal experiences, intuition, 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 was inspired to use video vignettes as a way to model and explore the benefits of positive parent-child responsive interactions, child-directed play, praise, coaching methods and discipline approaches as described above. Mediating the vignettes to trigger group discussions, problem-solving, exploration of potential barriers, and to set up coached practices allowed clinicians to tailor or individualize strategies to specific children or family situations as well as to strengthen parents' support networks with friends, family and teachers. Moreover, I discovered that video vignettes of parent-child interactions helped to normalize common parent traps and de-stigmatize their sense of failure as well as to help parents be more empathic to children's viewpoints, different developmental milestones and temperaments.

I began developing the child-directed play material in 1981 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. Many of the parents were people who were friends or had been in my doctoral dissertation study and were interested in being taped in support other parents. I spent thousands of hours examining these tapes to find the 30-second to 1-minute vignettes that illustrated a point about responsive, child-directed play. Here intuition and my gut reaction eventually determined my choice of over 300 small video segments for the first parent program. I would describe this process as a bit like searching for love, you can't 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 effect on the parents, were often dysregulating for them, 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 parents yelling or criticizing their children for their misbehavior. Currently there are fewer negative interaction vignettes in the programs than earlier versions and those less effective vignettes are fairly typical and set up to allow parents to share and practice how to improve upon the interactions and to be compassionate toward the parent models and their efforts in order to normalize their responses. This process is empowering for the parents as they sometimes recognize themselves and learn a better way to manage a particular situation.

In later years when our large expensive cameras with fourteen-inch reels of 2-inch wide quad videotape film ($300 per one hour reel) 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 of mealtimes, getting dressed, toilet training, taking a bath, doing a chore, resisting going to bed or doing homework. For some programs I also was the 2nd camera person

who did the close ups while the professional camera man would get the wide shots. I frequently felt I knew where the camera should be before my camera man did and this was likely because I knew what I was looking for. I developed many more vignettes than can be shown in a group session in order to give group leaders options to choose vignettes according to the specific group's ethnicity, age, gender and temperament of children. In recent years I also added vignettes of parents or teachers talking about their experiences in the IY parent program. This was valuable because it helped forecast parents' success with the program if they continued to use the strategies and showed how other parents had helped foster their children's social and emotional development.

Once I had put together a set of vignettes that demonstrated a specific concept such as emotional coaching, I then wrote narrations to proceed each set of vignettes. The narration's purpose was to review the main developmental, social, emotional, or behavioral principle and to focus the parents on what to watch for while viewing the vignette. I also felt a summary narration would assure that the information parents got was accurate, clear, and focused and would prevent groups or clinicians going off on other tangents unrelated to primary topic for a particular session. In the leader manual I also suggested open-ended leader questions related to parent or child cognitions, behaviors or emotions for each of the vignettes. The objective was to keep the discussion focused on the key learning principles that the leader wanted the parents to discover and apply these to their individual goals in discussion and practices.

IY Processes and Methods Development

Once I developed the vignettes and key content, my next learning process was how clinicians could effectively mediate these vignettes to build on the strengths of the parents by inviting safe discussion, parent reflection, problem solving and parent discovery of the key

principles as well as using them to trigger practices based on parents' unique goals for themselves and their children. In other words, what were the important clinical methods and processes underlying fidelity delivery of a video-based program? This included how clinicians should handle parents' resistance to new concepts, or vignettes, or suggestions to practice? How often should a clinician pause a video vignette to foster parent group discussions and discovery of important interaction principles, or to trigger a practice related to their individual goals for themselves and their children? How many vignettes should be shown in one session? How much time should be spent on video versus live modeling techniques, or discussion versus practice exercises in order to bring about change in parents' thoughts or feelings or behavioral patterns? 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 can clinicians use the video vignettes to motivate parents to do the assigned home activities? How collaborative or prescriptive does the clinician leadership style needed to be? When would confrontation or direct teaching be useful? How can the clinician 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? How much attention is given to changing parents' thoughts and emotions and past experiences versus targeted behaviors? It became clear to me in watching hundreds of video hours of different clinicians delivering the program over many years that in addition to clinicians having adequate cognitive social learning and child development knowledge, clinician relationship characteristics (affect, warmth, humor, support, leadership) and having the clinically therapeutic and collaborative skills to promote the parent discovery process and to tailor the

program principles to parents' goals with group practices was an important determinant of positive parent outcomes. As technology improved from early VHS machines where you could not "freeze" a vignette for discussion or skip vignettes to DVD format, vignettes could be used in more therapeutic and collaborative ways. The digital DVD revolution allowed me to develop menus so that clinicians could more easily choose the best vignettes for a particular group and could easily freeze vignettes for discussion, role plays and rewind to view again. Eventually I developed both a *parent group leader process checklist and a self- and peer evaluation form* as well as *session protocols* for treatment vs prevention program delivery. **(See web site http://www.incredibleyears.com/certification-gl/basic-program/.** I have written much about the IY collaborative process of developing group rules, tailoring to personal goals, mediating video vignettes, promoting self-reflection and self-monitoring, setting up group planned practices and spontaneous practices, implementing and reinforcing home practice experiences and enhancing group support (Webster-Stratton, 2012). Each session format starts with a benefits-barriers exercise that encourages parents to discuss their personal challenges to using the skills being taught as well as to explore the benefits for using them in terms of how they will help them achieve their goals. The discussions use a problem solving format, that is, identifying the problem, identifying the alternative positive opposite behavior, practicing possible solutions, reviewing barriers and how to overcome them and reviewing both short term and long term goals. I believe these methods and processes are key to participant's ability to make meaningful changes.

This lead to emphases on key IY relationship clinician strategies which are looked for when a clinician goes for certification. Here are the key roles:

Clinician Role #1: Building positive and collaborative relationships through strategic self-disclosure, humor, optimism and encouragement, advocating, individual goal setting and weekly clinician phone calls.

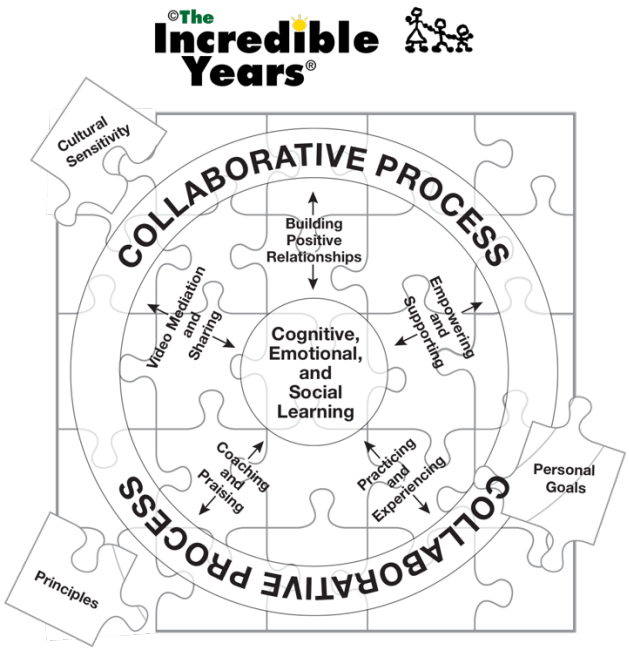
Clinician Role #2: Empowering parents through praise and validation, modifying powerless thoughts, promoting self-empowerment, respecting and valuing cultural diversity.

Clinician Role #3: Building parents' support team through group support, parent buddy calls, family support.

Clinician Role #4: Using evidence-based teaching and learning methods such as explanation and persuasion, generalizing and contextualizing the learning process, principles training, tailoring the teaching process to individual parent's learning style, reviewing and summarizing, individual behavior support planning, weekly home activity practice assignments, weekly reading assignments, self-monitoring checklists, weekly evaluations and effective time management.

Clinician Role #5: Interpreting & changing parents' cognitions through the use of analogies and metaphors such the IY parent tool box, reframing parents' perspectives and cognitions, prophesizing positive success as well as resistance and setbacks and making connections to temperament styles and past experiences.

Clinician Role #6: Leading and challenging parents to stay focused, setting limits and sufficient group structure, pacing group learning depending on parents' prior knowledge and experience, dealing with resistance and helping parents evaluate the benefits and barriers of the skill the parents were learning.



The Incredible Years Collaborative Learning Process

How Research Affected Incredible Years Ongoing Program Development

Throughout my 35-year career I continued to offer parent groups on a regular basis. This clinical work funded by my NIH grants to conduct randomized control group trials (RCTs) was the fuel that motivated me to revise and improve the IY programs because of the ongoing weekly session evaluations from parents and video reviews of our sessions. In addition, final summative parent evaluations plus parent and teacher reports on standardized measures and observations of parent-child interactions meant that I could find out what worked or didn't work to improve parent or child behaviors 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 but provided more social support, was more cost efficient, and actually resulted in more sustained results at 1-year follow-

up (Webster-Stratton, 1984) I was committed to the group model as one of the core therapeutic IY methods. Subsequent research helped me understand other key components of program delivery and to tailor my interventions to include the most effective group methods, processes, and content.

Refining and Expanding

The IY Parent Program content emerged from the risk factor research and was designed to reduce the malleable family risk factors including ineffective parenting, harsh discipline, maternal depression, poor attachment, chronic neglect, marital discord, lack of support, and low parent involvement with teachers. It was also designed to increase protective factors such as responsive, nurturing parenting, positive thinking, problem solving and stress management, positive discipline and parent and teacher support networks. 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 Program 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. The IY Teacher and Child Programs content focused on reducing school risk factors such as poor classroom management skills, poor social and emotional teaching, teacher stress, low parent involvement, and classroom aggression. Protective factors to be increased included teacher proactive teaching strategies, positive teacher-parent relationships, school support networks, and children's emotional regulation, positive friendships, effective problem solving, and school readiness skills. The underlying theory is that positive school experiences when children are young will strengthen children's social, emotional, and academic development and in the long

term prevent the development of conduct disorders, peer rejection, academic failure, depression, delinquency and substance abuse. See web site for parent, teacher and child program objectives and content and research studies. 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 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, 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. 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 and curriculum programs and training videos have continued to be refined and created for different populations. For example, the parent program now has 4 different versions for distinct developmental ages from infants to preteens. I found parent groups covering parenting for children ranging in age from toddler to pre-adolescent often resulted in confused parents using developmentally inappropriate parenting strategies such as trying to problem solve with a toddler or failure to understand how to promote family responsibility in a school age child. It was important that parents understood the developmental milestone for each age group. I also developed a shorter, universal parent intervention program designed for all parents of children 2-6 years (Attentive Parenting), a new program for day care providers and preschool teachers working with younger children (1-2 & 3-5 years) (Incredible Beginnings) and two new programs for parents and teachers working with young children on the autism spectrum (2-5 years).

Making the Decision to Disseminate ~ Challenges and Successes

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. In 1987 I had a contract with the university that acknowledged this ownership and permitted me to use the programs for training and grant research purposes

and outlined that all further work related to marketing, trainings, and further product development would be done at my own expense outside of the university. Up until my retirement (2011) I submitted financial disclosure forms yearly and participated in ongoing reviews regarding potential conflict of interest.

Eighteen years after publication of my first study with the parent program, I began to be contacted for information about obtaining program materials and training possibilities. Largely these requests came from countries such as UK, Norway, Denmark, New Zealand, and the Netherlands who had reviewed the research evidence and were interested in both delivering the IY programs as well as researching their effectiveness for use in their population. This upsurge in interest from others combined with reduced grant funding led to my decision to start an independent business to disseminate the programs. This was not in my career plan but would allow me to fulfill my goal of helping others deliver the IY programs with fidelity! I began by hiring an administrator to answer requests and set up training workshops as well as staff to help design manuals and further develop training materials. A few years later, when my NIMH Research Scientist Award ended, as a tenure-track professor I was faced with the decision of returning to a much heavier teaching load to justify my university salary, staying on research money myself but letting go of most of my clinical staff at the University Parenting Clinic, or making an increased commitment on my own to dissemination. I decided to give up half my tenure salary and reduce my time at the university. My career then consisted of half-time research at the university and the other half time engaged in disseminating the Incredible Years Programs with the goal of improving training materials and intervention protocols, training other clinicians in program delivery and consulting with others doing research with IY programs.

Having spent three decades as the developer of the Incredible Years series researching, redesigning, adapting, and expanding comprehensive clinician manuals, video vignettes and protocols, I believed we had the tools to begin disseminating the Incredible Years Programs. I thought it would be easy for clinicians to deliver the IY programs with fidelity because of the use of videos, comprehensive manuals, parent, teacher and child books, and clear session protocols. At that time, it was unclear to me whether clinicians would even need training because I believed everything was clearly articulated in the videos, leader manuals and protocols. Moreover, we had videos of sample group sessions designed to model and show clinicians how to deliver the programs. However, I quickly learned that developing an evidence-based program is only the first of many foundational steps needed to construct a quality and stable program. It was clear from my video reviews of clinician group sessions than neither the videos or workshops alone were sufficient to promote fidelity delivery. Clinicians needed help understanding how to tailor the discussions and learning to individualize key management principles to parents' and teachers' settings, goals, and cultural context as well as children's development level and diagnoses. I also had much to learn about overcoming the agency barriers involved in implementing an evidence-based program as well as the difficulties of bringing about changes in clinician cognitions, emotions and behaviors and resistance to a protocol-driven group approach. This real-world experience led to a successful grant application to study ways to promote clinician fidelity delivery of the IY programs. The results of this study revealed the added benefits of ongoing coaching and support for clinicians after their initial training workshops as well as training to help agency administrators understand how to support their clinicians to achieve certification (Webster-Stratton, Reid, & Marsenich, 2014). As I learned from our work with parents, for clinicians to change their clinical approach from an individual perspective to a

group collaborative video-modeling experiential evidence-based program, ongoing consultation and support would be needed not just a workshop. When my last research grant was not funded, I retired from the university to pursue the dissemination journey in more depth by providing quality training and consultation by certified trainers and mentors 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 most important content and processes for program delivery and show positive research results. This was perhaps the easiest part. I found it was also necessary to develop a comprehensive training process including ongoing support and consultation for the clinicians as well as for the administrators. The metaphor I use for developing and scaling up an EBP is that it is like building a house where there must be an architect (program developer) who takes advantage of changing technology and collaborates with the family as to their traditions, needs and goals, a committed contractor who monitors quality of building structure (agency administrator), onsite project managers to support and train construction builders (mentors and coaches) and a well-trained team of construction builders (clinicians). If there are barriers to any of these links the building will not be sound. For example, when there are agency and clinician barriers to disseminating evidence-based programs, it is as if the contractors hired electricians and plumbers who were not certified, disregarded the architectural plan and used poor quality, cheaper materials. Under these conditions, everyone would agree the building will not be structurally sound. Just like building a stable house, it is important that the foundation and basic structure for delivering evidence-based programs be strong. This includes careful agency program selection, support for clinicians, agency/administrative buy-in, and adequate funding.

With a supportive infrastructure surrounding the program delivery, initial investments will eventually pay off in terms of strong outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

The Incredible Years Program Training Series has been set up with a supportive infrastructure of 8 building blocks designed to promote program fidelity. These include accredited IY trainers, mentors and coaches, and an accreditation/ certification procedure that assures that the architectural plan is adhered to and that strong supportive scaffolding is provided for clinicians. One of the strengths of the IY series has been the attention given to fidelity adherence and certification/accreditation. For more information about how to scale up the IY programs slowly and carefully with fidelity be engaging in a collaborative project with strong links between the developer, agency administrator, trainers, mentors, coaches, clinicians, teachers and families using 8 key foundational building blocks or fidelity tools see the following article (Webster-Stratton & McCoy, 2015).

Successful Implementations

The Incredible Years Series is now widely used in 18 countries. Currently there are 8 accredited trainers, 75 mentors, and 110 peer coaches providing training and support to IY clinicians. Over the past 10-12 years these countries have trained a substantial number of clinicians who are offering the programs in a variety of settings including Head Start, Sure Start, and primary grade schools, primary care doctor's offices, mental health centers, community health centers, jails, families' homes, YMCA, homeless shelters, private practices, and businesses. Professionals such as nurses, doctors, social workers, psychologists, teachers, and community mental health works have targeted not only parents and teachers for this training but also foster parents, day care workers, teen parents, and early childhood teachers. The programs have been delivered with

fidelity on small and large scales in a variety of settings. These successful implementation models all share the common features of agency, state, or government financial support and one or more staff members who developed a strong interest and passion for advancing IY in that setting. These internal champions gradually developed expertise in IY, often conducted research evaluations with their population, shared information with colleagues, and developed a plan for rolling out the program over time. Although the detailed strategies described above may sound daunting to consider all at once, they provide organizations and countries with a roadmap to be revisited as an agency or states or countries gradually adopt and scale up IY programs. Moreover, through problem solving conversations with IY headquarters and the developer and trainer team, collaborative plans can be made to determine how to make IY uniquely fit in the context of a particular organization or country or state using the Incredible Years guidelines and principles described.

Lessons Learned and Next Steps

My experience scaling up IY has taught me that EBP development must be thought of as an ongoing building process rather than an endpoint. New data will continually emerge to inform real world clinical practice and each unique setting or environment can inform improvements or adaptations to the construction process and further research. For example, our work with child welfare referred families led us to expand the number of sessions needed for this population as well as to include the Advance program that focused on interpersonal problems such as depression, anger management, and problem solving and also to develop protocols for home-coaching sessions to supplement the group experience. Our experience working with a subsample of children in our studies with co-morbid ADHD and Autism Spectrum diagnoses led us to develop additional vignettes and programs to address these populations. Additionally, the

IY Series implementation manuals (including handouts, books and resources given to participants) are constantly being updated with new research and feedback, video VHS technology has been replaced by DVDs and USBs and now includes more cultural diversity and languages, and even the suggested number of sessions has been expanded upon because of more complex and culturally diverse populations and children's different needs and also because of years of experiences and feedback from participants as to what they want help with. 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 research 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 broader 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 successful transporting efficacious practices like IY into real world settings with diverse cultural populations. Some of the critical factors include selecting optimal clinicians to deliver the program; providing them with quality training workshops coupled with ongoing supportive mentoring and consultation, on-site peer and administrative support; facilitative supports; and ongoing program evaluation and monitoring of program dissemination fidelity. At the same time, it has 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 whether you are trying to change parent, or teacher, or therapist behaviors, or agency administration and funding policies, bringing about change is not simple and requires a committed, persistent and collaborative team who believe change is possible and are not undaunted despite resistance. Moreover, I have also learned that technology such video is an important adjunct tool but not sufficient because in the end as I learned years ago in Africa it is the ongoing relationship building that is key to bring about innovative change. Only if we invest the resources in methods known to sustain high-quality evidence based practices can we be sure our building construction is solid and our time and efforts have not been wasted. 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 changes in children makes it well worth the effort.

Ainsworth, M. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M. Richards (Ed.), *The integration of the child into the social world*. Cambridge: Cambridge University Press.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs: Prentice-Hall, Inc.

Bandura, A. (1982). Self-efficacy mechanisms in human agency. *American Psychologist, 84*, 191-215.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness, and depression*. New York: Basic Books.

Houlihan, T. M. (2013). *The Incredible Years Dinosaur School Programme: An interpretative phenomenological analysis of children's experiences.* University of Limerick, Limerick.

Menting, A. T. A., Orobio de Castro, B., & Matthys, W. (2013). Effectiveness of the Incredible Years Parent Training to Modify Disruptive and Prosocial Child Behavior: A Meta-Analytic Review. *Clinical Psychology Review, 33*(8), 901-913.

Patterson, G., Reid, J., & Dishion, T. (1992). *Antisocial boys: A social interactional approach* (Vol. 4). Eugene, OR: Castalia Publishing.

Piaget, J., & Inhelder, B. (1962). *The Psychology of the Child*. New York Basic Books.

Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology, 52*(4), 666-678.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology, 62*(3), 583-593.

Webster-Stratton, C. (2012). *Collaborating with Parents to Reduce Children's Behavior Problems:A Book for Therapists Using the Incredible Years Programs* Seattle, WA Incredible Years Inc.

Webster-Stratton, C., & McCoy, K. P. (2015). Bringing The Incredible Years programs to scale. In K. P. McCoy & A. Dianna (Eds.), *The science and art, of program dissemination: Strategies, successes, and challenges. New Directions for Child and Adolescent Development* (Vol. 149, pp. 81-95).

Webster-Stratton, C., Reid, J., & Marsenich, L. (2014). Improving Therapist Fidelity During Evidence-Based Practice Implementation *Psychiatric Services, 65*(6), 789-795.