16 An Integrated Approach to Prevention and Management of Aggressive Behavior Problems in Preschool and Elementary Grade Students

Schools and Parents Collaboration

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Introduction

Teachers across the nation daily face classrooms with increasing numbers of students who exhibit "conduct problems," characterized by high rates of aggression, inattention, hyperactivity, defiance, and noncompliance. Conduct problems are escalating at younger ages (Campbell, 1995; Webster-Stratton & Hammond, 1998), and prevalence rates indicate that 7% to 20% of preschool and early school-age children meet the diagnostic criteria for oppositional defiant disorder (ODD) or conduct disorder (CD). These rates are even higher for low-income families (Offord, Boyle, & Szatmari, 1987). Not only are aggressive children a management problem, but they often need extra assistance with co-occurring academic problems such as learning, reading, and language delays (Bryan, 1991; Gresham, 1986;

Kavale & Forness, 1998) (see Chapter 1 by O'Shaughnessy, Lane, Gresham, & Beebe-Frankenberger, this text).

The need for teachers and parents to manage young aggressive and noncompliant children successfully is particularly urgent because, if left unmanaged, these behaviors are stable over time and appear to be the most important behavioral risk factors for antisocial behavior in adolescence (Offord et al., 1987). Early behavior problems are repeatedly identified as predictor of later drug abuse (Brook, Whiteman, Gordon, & Cohen, 1986; Dishion & Ray, 1991), juvenile delinquency, violence, and school dropout (Kazdin, 1995; Tremblay, Mass, Pagani, & Vitaro, 1996). Unfortunately, the rise in schools' zero-tolerance policies (suspension and expulsion) for antisocial behavior increases the likelihood that such children will leave school early without the assistance they need. Recent projections suggest that approximately 70% of young children with conduct problems do not receive services (Hobbs, 1982; Kazdin & Kendall, 1998), and even fewer receive empirically supported interventions. Interestingly, the majority of youth who receive any help for a mental health problem receive interventions within the school, but such services tend to be brief and often do not result in sustained change.

Causes of Conduct Problems

Theories regarding the causes of child conduct problems include child biological and developmental risk factors (e.g., attention deficit disorders, learning disabilities, and language delays); family factors (e.g., marital conflict, depression, drug abuse, and criminal behavior); ineffective parenting (e.g., harsh discipline, and low parent involvement in school activities); school risk factors (e.g., teacher's use of poor classroom management strategies, classroom level of aggression, large class sizes, and low teacher involvement with parents); and peer and community risk factors (e.g., poverty and gangs). Emerging data suggest that there are no clear-cut causal links between single risk factors and a child's academic and social-emotional problems; most of these factors are intertwined, synergistic, and cumulative (Group, 1992; Hawkins & Weiss, 1985; Reid & Eddy, 1997). For example, a child who is temperamentally hyperactive, impulsive, and inattentive will be more difficult to parent or teach. This child will be more likely to receive harsh discipline than encouragement. This critical discipline style will not promote prosocial behaviors and provides negative models of behavior, thereby further impeding the development of adaptive social-cognitive skills. Family stress, such as that associated with unemployment, marital difficulties, and poverty, often contributes to ineffective parenting, resulting in poor cognitive stimulation and academic support. Upon school entry, behavioral and academic problems are likely to result in frequent discipline from the teacher and peer rejection. This leads to fewer opportunities to practice both academic and social skills and poor parent and child school involvement. Teachers may misunderstand the reasons for lack of parental involvement and respond more critically to the parent, further eroding the bonds between the home and school. Moreover, teachers may lack the knowledge, skills, and resources to assist children with behavior problems and their families. Poor

classroom management may result in increasing levels of classroom disruption/aggression, which can have significant effects on the individual child's risk for continuing aggression. Thus, spiraling risk factors continue the cycle of developing conduct problems over time. A more complete review of etiological factors can be found elsewhere (e.g., Stoff, Breiling, & Masters, 1997).

Implications of Risk Factors for Preventive Intervention

The Earlier the Intervention the Better

The developmental model illustrating cascading risk factors as children transition to school and the longitudinal research on the poor prognosis for "early starter" aggressive children suggest that early intervention is crucial. Evidence indicates that the earlier intervention is offered, the more positive the child's behavioral adjustment and the greater chance of preventing later delinquency (Taylor & Biglan, 1998). In fact, there is some evidence that if children with conduct problems are not treated by age 8, their problems become less responsive to intervention and more likely to become chronic (Bullis & Walker, 1994; Francis, Shaywitz, Stuebing, Shaywitz, & Fletcher, 1991). Developmental research indicates that these "early-starters" can be identified at school entry by the occurrence of aggressive problems across the home and school settings (Campbell, 1995; Group, 1999a). Researchers have demonstrated that violent adolescents could be identified with almost 50% reliability by at least age 6 (Campbell & Ewing, 1990; Group, 1999a; Loeber et al., 1993; Tremblay et al., 1999). The transition to school is a strategic time to begin early intervention since this time can be stressful for parents and children. Key developmental issues for high-risk children at school entry are the control of aggressive behavior, the acquisition and use of prosocial skills, positive relationships with others, and the development of a positive interest in school.

Target Multiple Risk Factors

Significant advances in the conceptualization of the practice of prevention science in mental health (Mrazek & Haggerty, 1994) emphasize that interventions must target multiple risk and protective factors and be tied to theoretical and life course models. Programs should be developmentally based and target reductions in risk factors such as harsh discipline as well as increase in protective factors such as children's social and academic competence. This comprehensive model could be the single most important step in preventing and reducing conduct problems before they "cascade" (Patterson, Reid, & Dishion, 1992) across developmental periods and result in cumulating and intensifying risk factors (Bierman, Miller, & Stab, 1987; Coie, 1990a, 1990b; Dodge, Bates, & Pettit, 1990). In summary, this multi risk factor view of the development of conduct problems indicates that interventions for at-risk children must begin early and address both home and school risk factors.

Effective Intervention Strategies

This chapter will describe empirically supported family and parenting interventions that can be offered by schools to reduce conduct problems and promote social and academic competence. "Empirically supported" interventions will be defined here based on the Chambless and Hollon criteria (1998), a standard that is generally accepted in the scientific community (APA Task Force on Psychological Intervention Guidelines, 1995). This standard relies on interventions being evaluated in randomized control designs, demonstrating changes in observations of behavior (not only in parent or teacher reports), replication by an independent research group, provision of detailed training manuals and intervention materials, and publication in peer-reviewed journals. These criteria promote selection of interventions that are based on evidence about what is proven to work for conduct problem children and their families.

Family-Focused Interventions

Rationale for Parent Training.   Parenting interactions are clearly the most well-researched and proximal causes of conduct problems in children. Research shows that some parents of children who are highly aggressive lack certain fundamental parenting skills (Patterson, 1982). For example, parents of such children may be less positive and more coercive, permissive, erratic, and inconsistent. They are less likely to monitor behavior and more likely to reinforce inappropriate and ignore prosocial behaviors (Chamberlain, Reid, Ray, Capaldi, & Fisher, 1997; Reid & Eddy, 1997). These parental constructs at age 10 predict later antisocial behavior and drug abuse (Patterson, Crosby, & Vuchinich, 1992). Many factors disrupt parenting, including family life stressors (often associated with socioeconomic disadvantage) (Forgatch, 1989; Forgatch, Patterson, & Skinner, 1988; Wahler & Sansbury, 1990; Webster-Stratton, 1990a); maternal insularity and lack of support (Wahler, 1980); parental psychopathology or substance abuse (Kazdin, 1987); and marital discord (Cummings & Davies, 1994; McMahon & Forehand, 1984; Webster-Stratton & Hammond, 1999). Low parent involvement in school also puts children at risk for academic failure and antisocial behavior (Reid & Eddy, 1997).

Parent training programs help counteract the *parent and family risk factors* by teaching positive, nonviolent discipline methods and supportive parenting that promotes children's self-confidence, prosocial behaviors, problem-solving skills, and academic success. Parent interventions help parents respond effectively to normal behavior problems so that these problems do not escalate. Parents learn to provide support for their children's cognitive, social, and emotional growth. Parent training programs can also help parents communicate effectively with teachers and advocate for their child's social and academic development. Group format parent training that also focuses on family issues such as communication and problem-solving skills addresses some of these family risk factors by facilitating parent support, decreasing parents' isolation, and providing strategies to cope with stressful life events.

Empirical Validation for Parent Training Programs. Extensive research indicates that parent training is the single most effective intervention available for reducing early conduct problems (Kazdin, 1985; Tanaka, 1987; Taylor & Biglan, 1998). In a review of 82 empirically tested psychosocial interventions for conduct problem children and adolescents (Brestan & Eyberg, 1998), the two found to be effective were parent training programs: a program derived directly from Patterson's social learning model (Patterson & Chamberlain, 1988) and a program based on videotape modeling developed by Webster-Stratton (Webster-Stratton, 1996; Webster-Stratton & Hancock, 1998). Of the 10 additional programs judged to be "probably efficacious," three were parent training or family therapy programs. Likewise, a review by Kazdin and Kendall (1998) of interventions for treating antisocial children found that two of four interventions showing the greatest promise emphasized the family.

The successful short-term outcome of parent training has been repeatedly verified by significant changes in parents' and children's behavior and adjustment (Dishion & Andrews, 1995; Eyberg, Boggs, & Algina, 1995; Kazdin & Kendall, 1998; Patterson & Narrett, 1990; Webster-Stratton & Hammond, 1997). Home observations indicate reductions in children's levels of aggression by 20% to 60% (Patterson, Chamberlain, & Reid, 1982; Webster-Stratton & Hammond, 1997). Researchers have found improvements in other outcomes, including school dropout and attendance, disruptive behavior, and criminal activity (Kazdin, Siegel, & Bass, 1992). Generalization of behavior improvements from the clinic setting to the home over reasonable follow-up periods (1–4 years) and to untreated child behaviors have also been demonstrated (Taylor & Bilan, 1998). Studies typically find that approximately two-thirds of children show clinically significant improvements, which means that their behavior falls in the normal range following the family intervention (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). There is mixed evidence on generalization of improvements from home to school; parent training studies have indicated that improvements in the child's behavior at home are not necessarily associated with improved peer relationships, particularly if teachers are not involved in the intervention. Evidence does indicate that early intervention has longer-lasting effects when parent programs incorporate a cognitive/academic component (Yoshikawa, 1994). Programs are also more likely to generalize when parent training is combined with child and teacher training (Kazdin, Esveldt-Dawson, French, & Unis, 1987; Kazdin et al., 1992; Webster-Stratton & Hammond, 1997; Webster-Stratton & Reid, 1999c).

For older adolescents with conduct disorders, an intensive parent component, as a part of a more comprehensive therapeutic program, is necessary for reducing violence. In addition to parent education programs reviewed later in this chapter (under model programs), research supports the effectiveness of multisystemic therapy (MST) (Henggeler, Melton, & Smith, 1992; Henggeler, Schoenwald, & Pickrel, 1995) and functional family therapy (Alexander & Parsons, 1982; Morris, Alexander, & Waldron, 1990). MST is a comprehensive, family-oriented program that has been effective in reducing a variety of antisocial and delinquent outcomes (Henggeler, Schoenwald, Borduin, & Rowland, 1998). Programs based on

this model use individualized wraparound service plans for each child and family, an approach familiar to school psychologists (Eber & Nelson, 1997). See Eber and Nelson (1997) for an example of how schools can assume the lead role in a system of care. Although family therapy is critical for older students with chronic behavior problems, less intensive parent interventions are sufficient for most younger students. Christenson, Rounds, and Franklin (1992) and Sheridan, Kratochwill, and Bergan (1996) present thorough reviews of home–school collaboration strategies found to be effective in preventing and reducing children's academic and social problems.

School-Based Prevention Strategies

Rationale for Parent Training in School Settings.   While parent training historically has not been seen as an essential element of school services, there are several advantages to offering parent training in a school-based preventive model rather than in a mental health setting. First, school-based programs are ideally placed to target multiple risk factors in the child, family, and school and build links between these three areas. Second, school-based programs are more accessible to families and eliminate the stigma associated with services offered in traditional mental health settings as well as some of the practical and social barriers to treatment access (e.g., lack of transportation, insurance, child care, or financial resources). Third, school interventions can be offered before low-level behavior problems have escalated into severe problems that require referral and extensive clinical treatment. Moreover, when intervention is offered in communities, these communities become natural sources of support for parents and teachers (Webster-Stratton, 1997). Lastly, on-site school interventions can provide services to high numbers of high-risk families and children at comparatively low cost.

Empirical Validation of School-Based Prevention.   As indicated by the preceding review, there is extensive knowledge about the development and treatment of conduct disorders using parent training. Work in the area of prevention of conduct problems is also extremely promising. In the past decade several multifaceted, randomized control, longitudinal prevention programs have shown that rates of later delinquency and school adjustment problems can be lowered by early parent–school intervention. Tremblay and colleagues (Tremblay, Pagani, Masse, & Viatro, 1995; Tremblay et al., 1996) found that a combination of parent and child training for high-risk children in kindergarten and first grade reduced delinquency and school adjustment problems at age 12. Similar findings using child and parent training for fourth- and fifth-grade students were reported by Lochman and Wells (Lochman & Wells, 1996). FAST TRACK, a large scale, multicenter, multicomponent program, provided ongoing services to children exhibiting conduct problems from first to fifth grade. The intervention included a classroom management component, social skills training called PATHS, (Kusche & Greenberg, 1994), academic tutoring, parent training (based on Forehand, Rogers, McMahon, Wells, & Griest, 1981), home visits, and friendship enhancement. Outcome at 1 and 3 years showed reductions in conduct problems and special education resource use

(Group 1999a, 1999b). The LIFT project (Reid, Eddy, Fetrow, & Stoolmiller, 1999), another school-based prevention program, provided parent training, classroom social skills training, a behavioral playground program, and a parent–teacher communication program to all students in high-risk schools. Results showed intervention effects on physical aggression, behavior improvements in the classroom, and reductions in maternal aversive behavior at home (Reid et al., 1999). Two randomized prevention trials of Webster-Stratton's parent intervention program (The Incredible Years Training Series) produced positive change in Head Start parents and their 4-year-old children immediately at posttreatment and at 1-year follow-up. Intervention produced positive changes in parenting, parents' school involvement, children's levels of aggression, conduct problems, and social skills (Webster-Stratton, 1998b; Webster-Stratton & Reid, 1999c).

Prevention Programs That Include Teacher Training

To promote student's behavioral and academic success, teachers must be well trained in effective classroom management. Schoolwide approaches that provide consistent classroom discipline plans and individualized plans for children with conduct problems can be highly effective (Cotton & Wikelund, 1990; Gottfredson, Gottfredson, & Hybl, 1993; Knoff & Batsche, 1995). Specific teacher behaviors associated with improved classroom behavior include the use of high levels of praise and social reinforcement (Walker, Colvin, & Ramsey, 1995); proactive strategies such as preparation for transitions and clear, predictable classroom rules (Hawkins, Von Cleve, & Catalano, 1991); short, clear commands, warnings, reminders, and distractions (Abramowitz, O'Leary, & Futtersak, 1988; Acker & O'Leary, 1987); tangible reinforcement for appropriate social behavior (Pfiffner, Rosen, & O'Leary, 1985); team-based rewards (Kellam, Ling, Merisca, Brown, & Ialongon, 1998); mild but consistent response costs (time-out or loss of privileges) for aggressive or disruptive behavior (Pfiffner & O'Leary, 1987); and direct instruction in appropriate social and classroom behavior (Walker, Schwartz, Nippold, Irvin, & Noell, 1994) and problem-solving skills (Shure & Spivack, 1982).

Classroom management training is promising in demonstrating short-term improvements in disruptive and aggressive behavior in the classroom for approximately 78% of disruptive students (Stage & Quiroz, 1997). Programs such as ACHIEVE (Knoff & Batsche, 1995) and BASIS (Gotfredson et al., 1993) that focus on classroom management skills and discipline, social skills training, and home–school collaboration are effective in reducing teacher reports of antisocial behavior and improving academic achievement. However, these studies did not use randomized control designs or measure the programs' effects across settings and over time.

Several studies using randomized control designs have extended this teacher training research. Two large-scale prevention projects, the Seattle Social Development Project (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999) and the Child Development Project (Battistich et al., 1991), emphasized training teachers in classroom management. Six-year follow-up of the Hawkins study (Hawkins et al., 1999) with children who received school-based intervention in first through fifth grades

showed reduced violent delinquent acts, lower drinking age, less sexual activity, and fewer early pregnancies. Child Development Project results show improvements in prosocial and problem-solving skills (Battistich, Schaps, Watson, Solomon, & Schaps, 1989). A follow-up study of these children demonstrated intervention students were less likely to use alcohol and exhibited fewer delinquent behaviors (Battistich, Schaps, Watson, & Solomon, 1996). Webster-Stratton (Webster-Stratton & Reid, 1999b, 1999c) evaluated the combined effects of parent and teacher training in two randomized control studies, as prevention in Head Start and as treatment with a sample of diagnosed 4- to 8-year-old children. The teacher program significantly enhanced the effectiveness of parent and child training in terms of decreasing aggressive behavior in the classroom, promoting academic readiness, and increasing on-task work. Moreover, participating teachers were observed to use fewer inappropriate and harsh discipline strategies and to be more nurturing and positive than nonintervention teachers.

Key Features of Effective Parent Programs

Several excellent literature reviews indicate that cognitive-behavioral family interventions are helpful for prevention and treatment of conduct disorders and promotion of social competence (Brestan & Eyberg, 1998; Taylor & Biglan, 1998). These reviews can help schools evaluate the appropriateness of particular parenting programs for their needs. Based on research, schools are advised to use the following guidelines to select an effective parenting/teacher intervention.

Broad-Based Content.   Program content and process must be relevant and sensitive to individual parent needs and circumstances. A focus on problem solving, communication with teachers, personal family issues, and other risk or protective factors in addition to parenting skills is more effective. Moreover, the combination of child *and* parent training results in better early peer interactions and later reductions in delinquent behavior and drug abuse (Kazdin, Bass, Siegel, & Thomas, 1989; Kazdin, Esveldt, French, & Unis, 1987; Kazdin et al., 1992; Webster-Stratton & Hammond, 1997). Although all these facets of interventions are not required for every family, the ability to integrate them into treatment clearly enhances the effectiveness of parent training, especially when parents are coping with issues such as serious depression, drug abuse, marital discord, or extreme poverty.

Cognitive, Behavioral, and Affective Components.   Programs that emphasize parents' feelings and cognitions and promote self-management as well as teaching behavioral "principles" have higher consumer satisfaction and longer-lasting effects. Programs should include parent–child relationship building through positive parenting practices and child-directed play as well as behavioral strategies such as time-out and loss of privileges (rather than relying on exclusively one focus or the other).

Length Greater than 20 Hours.   Programs that are at least 20 hours (extending to 50 hours) in length have more sustained and significant effects (Kazdin, 1987). Parenting programs offered in schools can be provided across key transition points

such as entry to preschool, kindergarten, middle school, and high school. This approach provides a lengthier and more comprehensive approach and also provides parents with periodic "boosts" to keep up their efforts at home and to facilitate relationships with new teachers.

Early Intervention and Developmental Focus.   The earlier intervention begins, the more positive the child's behavioral improvements. This does not mean that programs for parents of antisocial adolescents should be eliminated but that it is far easier to impact behavior problems when children are young. Parenting programs should focus on a particular developmental stage and age. Programs that attempt to address issues for all ages are likely to fail because different parenting strategies are appropriate for children of different ages, and parents may be confused and frustrated by strategies that do not apply their own child's developmental level.

Collaborative Process.   Programs that are collaborative (i.e., parents are given responsibility for identifying their own goals and developing their own solutions with the guidance of the group leader) result in more parental engagement and fewer dropouts and are perceived as more culturally sensitive. When parents are involved in self-management (e.g., determining their priorities for home activities) and a coping or problem-solving model (vs. a mastery model) is used, programs are perceived as more meaningful and relevant to parents' needs and cultural traditions. This will result in greater parental attendance, retention, and behavior change (Webster-Stratton & Herbert, 1994).

Focus on Strengths.   Programs that focus on parents' strengths (as opposed to their deficits), assuming that even highly stressed parents bring knowledge and expertise regarding their child and their needs, result in less dropout, more involvement, and more behavior change.

Building Family and Social Support.   Programs that are offered in group format, encourage partners' involvement, and promote within-group relationships are more cost-effective. They also reduce parents' sense of isolation, increase their sense of support, reduce dropout rates, and result in lasting effects (Webster-Stratton, 1985).

Performance Training Methods.   Training methods need to be responsive to a variety of parental learning styles and should utilize "performance-based" training methods such as videotape modeling, role playing, and home practice assignments. Direct feedback, instruction, and active practice of skills are more effective than "verbal-based" learning methods such as discussion and written handouts.

"Principles" Training.   There is greater behavior improvement and generalization when parents are taught behavioral principles (not just specific strategies). Parents who understand the rationale behind parenting strategies and their long-term results are more motivated to implement them.

Parent–Teacher Partnerships. Parenting programs that promote skills in school collaboration and help parents and teachers develop consistent home–school behavior plans are more effective than programs offered in isolation from schools and teachers. Programs that include teacher training result in more generalization and consistency of behavior improvements across settings.

Group Leader Clinical Skills. Leaders who are warm, collaborative, nonhierarchical, nonblaming, and supportive and demonstrate a coping model are more effective than program leaders who are "expert," distanced, and prescriptive. A collaborative approach (i.e., leader acts as a "coach" to provide support and encouragement) will facilitate active parent participation and interaction. The "expert" model frequently fosters passive resistance on the part of parents. It is important that leaders receive appropriate training and ongoing supervision until they are proficient with intervention implementation. Many empirically validated programs have developed certification procedures for assuring that the program is delivered with integrity and a high level of quality.

Sensitivity to Barriers for Low-Income Families. Programs should be accessible and realistic about the practical constraints of low-income families. This may mean providing child care, transportation, food, flexible meeting times, and community meeting places (Webster-Stratton, 1998a). Weekly support calls from leaders and group "buddy systems" help engage families and result in lower dropout and higher attendance rates, particularly in highly stressed families. Leaders can also help parents make up missed group sessions in a home-visit format.

Model Programs

The following discussion highlights several model parent/family training programs (with an emphasis on programs targeting younger children) that were selected on the basis of their widespread availability, detailed descriptions of training procedures, and empirical validation, including data concerning their long-term effectiveness in reducing conduct problems.

Parenting Programs from the Oregon Social Learning Center. The most highly influential parent training program was developed by Patterson, Reid, and their colleagues at the Oregon Social Learning Center. Spanning two decades of research with more than 400 families, their work provides an exemplary model for outcome research with conduct-problem children. Although directed toward parents of older children with conduct disorders, their program will be described here because it has provided the foundation for numerous other parent training programs.

The program uses an individual counseling model in a step-by-step approach wherein each newly learned skill forms the foundation for the next new skill. Five behavior management practices form the core content of the program: tracking behavior problems, using social and tangible reinforcement, using time-out and other limit-setting techniques, monitoring child behavior, and problem-solving/negotiation strategies. Parents become increasingly responsible for designing their

own programs. The treatment content is described in a manual by Patterson and Chamberlain (1988), elaborated upon by Reid et al. (1999), and has undergone extensive evaluation. An assigned text, *Living with Children* or *Families*, is used with the program.

Adolescent Transition Program. A group-based version of this program called the Adolescent Transition Program, Parent Focus (ATP; Dishion & Kavanagh, in press), was developed for parents of older children with at-risk behaviors (ages 11–15 years). This 12-session, group-based parenting program has been shown to improve both parenting practices and youth behaviors. The program uses videotape examples and discussion.

Helping the Noncompliant Child. Another influential parent training program for noncompliant 3- to 8-year-old children was developed by Hanf (Hanf & Kling, 1973) and modified and evaluated by McMahon and Forehand (1984). As described by Forehand and McMahon (1981) in their book *Helping the Noncompliant Child*, this comprehensive parent training program begins by teaching parents to engage in nondirective play with their children and to identify and reward children's prosocial behaviors through praise and attention. Parents then learn to increase child compliance using direct commands and time-out. Progression to each new skill is contingent on achieving competence in the previous skills. The therapist works with individual parents and children together. Training methods include role playing, modeling, coaching, and a "bug-in-the-ear" device so therapists can provide feedback during parent–child interactions. This intervention is effective in reducing noncompliance and conduct problems with long-lasting effects. ·

Parent–Child Interaction Therapy. An emphasis on improving parent–child relationships is also found in Parent–Child Interaction Therapy developed by Eyberg (Eyberg et al., 1995). While the importance of behavior management principles is maintained, child-directed play (describe, reflect, imitate, and praise) is a major focus of intervention. Eyberg presents this program as an integration of traditional play therapy and current behavioral thinking about child management. It is felt that nondirective parent–child play improves children's frustration tolerance, reduces the anger level of oppositional children, and offers opportunities for prosocial behavior to occur. Engaging in play also helps parents recognize children's positive qualities. Nondirective play teaches parents to respond in a sensitive and genuine manner, to relate to their child's development, and to stimulate learning.

The Incredible Years Parenting Programs. Another parent training program, The Incredible Years, developed by Webster-Stratton (1984, revised 2001) contains two 12- to 14-week programs (for ages 3–8 and 5–10). Based on the early theoretical work of Patterson (Patterson, 1976a, 1982; Patterson, Reid, Jones, & Conger, 1975) and Hanf (Hanf, 1970; Hanf & Kling, 1973) regarding key parenting and relationship skills and behavioral principles to reduce conduct problems, the program makes extensive use of videotape modeling methods. The content of the BASIC program incorporates Patterson's (1982) nonviolent discipline concepts, Hanf's

(1970) "child-directed play" approaches, and the strategic use of differential-attention, encouragement, praise, and effective commands. It also includes cognitive behavioral approaches such as problem-solving strategies, self-management principles, and self-talk to cope with depressive and self-defeating thoughts. This content has been embedded in a relational framework including parent group support and a collaborative relationship with the group leader. This approach is designed to promote parental self-efficacy and engagement with the program and reduce parental resistance and dropout (Webster-Stratton, 1998a; Webster-Stratton & Hancock, 1998). Parent discussion centers around the videotape vignettes that show parent models in natural situations (unrehearsed) with their children "doing it right" and "doing it wrong." Each parent identifies goals for the program and then applies the "parenting principles" learned in the program to their individualized goals. The group discussion and collaborative format were chosen to ensure that the intervention would be sensitive to individual cultural differences and personal values. A book for parents entitled *The Incredible Years: A Trouble-Shooting Guide for Parents* (Webster-Stratton, 1992), as well as a self-administered version of the videotape program, are also available. This program is effective as a prevention program (12 weeks) and as an intensive intervention (22 weeks) for parents of children with diagnosed ODD/CD.

In addition to the BASIC program (described earlier), Webster-Stratton has developed two other parent videotape training series. The first, The ADVANCE parent program, includes content on problem solving, communication, anger management, and support (Webster-Stratton, 1990b). This 14-week program enhances the effects of BASIC by promoting children's and parent's conflict management skills and self-control techniques (Webster-Stratton, 1994a). The other videotape program, *Supporting Your Child's Education*, helps parents support their children's learning at home and to communicate with teachers more successfully. This 6-week program results in increased parental involvement in school-related activities (Webster-Stratton & Reid, 1999c).

Finally, Webster-Stratton has developed two other videotape-based training programs, one for training children directly in problem-solving, anger management, and social skills (Webster-Stratton, 1990a, Webster-Stratton & Hammond, 1997) and the other for training teachers in positive classroom management strategies and effective methods of communicating and involving parents (Webster-Stratton, 1994b, Webster-Stratton & Reid, 1999a, 1999b).

Summary

As has been demonstrated in this chapter, a parent component is critical to the success of schools' efforts to provide programs for preventing conduct problems and promoting social competence in students. The review herein is not all-inclusive, focusing instead on a few programs that have been shown to be effective using rigorous evaluation standards. Given the powerful potential of these programs, school psychologists involved in preventing and reducing school aggression

should be trained in empirically validated interventions (Brestan & Eyberg, 1998) and consider strategies to integrate these effectively into a schoolwide plan. Central to any of these programs' success is the parent–teacher–school counselor partnership model, a supportive network that leads to parents and teachers feeling more supported in their efforts and results in more success than those that target either teachers or parents alone. When schools offer comprehensive intervention programs, they can expect to have reduced levels of conduct problems and school violence, increased academic success, and greater collaboration between home and school. Schools could initiate this process by routinely screening children to determine who could benefit from additional support, such as parent training or social skills programs. Then they could provide parenting programs by training school counselors, psychologists, nurses, or teachers so that they are confident in offering group-based parent programs. Moreover, they could provide a resource room for parents that includes books and videotapes on parenting, social skills, and problem-solving teaching for children. There is great need for schools to find the resources for such programs and to define their role as partners with parents in efforts to prevent conduct problems and promote social competence.

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