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The Incredible Years Program for Children from Infancy to Pre-adolescence: Prevention and Treatment of Behavior Problems

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OVERVIEW

The incidence of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in children is alarmingly high, with reported cases of early-onset conduct problems occurring in 4–6% of young children (Egger & Angold, 2006), and as high as 35% of young children in low-income families (Webster-Stratton & Hammond, 1998). Developmental theorists have suggested that "early starter" delinquents who first exhibit ODD symptoms in the preschool years have a twofold to threefold risk of becoming chronic juvenile offenders (Loeber et al., 1993; Patterson, Capaldi, & Bank, 1991) compared to typically developing children (Snyder, 2001). Children with early-onset CD also account for a disproportionate share of delinquent acts in adolescence and adulthood, including interpersonal violence, substance abuse, and property crimes. In fact, the primary developmental pathway for serious CDs in adolescence and adulthood appears to be established during the preschool period. Early onset conduct problems represent one of the most costly mental disorders to society because such a large proportion of

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R.C. Murrihy et al. (eds.), *Clinical Handbook of Assessing and Treating Conduct Problems in Youth*, DOI 10.1007/978-1-4419-6297-3_5,

antisocial children remain involved with mental health agencies or criminal justice systems throughout the course of their lives.

Risk factors from a number of different areas contribute to child conduct problems including ineffective parenting (e.g., harsh discipline, low parent involvement in school, and low monitoring) (Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict and parental drug abuse, mental illness, and criminal behavior) (Knutson, DeGarmo, Koeppl, & Reid, 2005); child biological and developmental risk factors (e.g., attention deficit hyperactivity disorders [ADHD], learning disabilities, and language delays); school risk factors (e.g., poor teacher classroom management, high levels of classroom aggression, large class sizes, and poor school–home communication); and peer and community risk factors (e.g., poverty and gangs) (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Effective interventions for children with conduct problems ideally target multiple risk factors and are best offered as early as possible. Conduct disorder becomes increasingly resistant to change over time, so early intervention is a crucial strategy for the prevention or reduction of conduct problems, violence, substance abuse, and delinquency. Children with ODD and CD are clearly identifiable as early as 3–4 years of age, and there is evidence that the younger the child is at the time of intervention, the more positive the behavioral adjustment at home and at school following treatment. Intervention that is delivered prior to school entry and during the early school years can strategically target risk factors across multiple domains; home and school, and through multiple change agents; parent, teacher, and child. Unfortunately, less than 20% of young children meeting DSM-IV criteria for ODD are referred for mental health services (Horwitz, Leaf, Jeventhal, Forsyth, & Speechley, 1992). Even fewer of those referred obtain evidence-based interventions.

THE INCREDIBLE YEARS TREATMENT PROGRAMS

To address the parenting, family, child, and school risk factors for children or adolescents with conduct problems, we have developed three complementary training curricula, known as the Incredible Years (IY) Training Series, targeted at parents, teachers, and children (from birth to 12 years). This chapter reviews these training programs and their associated research findings.

Incredible Years Parent Interventions

Goals of the parent programs. Goals of the parent programs are: (a) to promote parent competencies and strengthen families by increasing positive parenting, parent–child bonding and attachment, and self-confidence about parenting; (b) to increase parents' ability to use play interactions to coach children's social–emotional, academic, verbal, and persistence skills; (c) to reduce critical and physically violent discipline and increase positive discipline strategies such as ignoring and redirecting, logical consequences, time-out, and problem solving; (d) to improve parental self-control,

depression, anger management, communication skills, and problem solving; (e) to increase family support networks; and (f) to improve home–school bonding and increase parents' involvement in school-related activities so as to support their children's academic competence.

After more than 28 years of program development and evaluation, the IY parent treatment consists of a variety of comprehensive, empirically validated programs. Below we describe each of the well-researched parent programs and their targeted populations.

BASIC parent training treatment program. In 1980, we developed an interactive, video-based parent intervention program (BASIC) for parents of children ages 2–7 years. In subsequent years, we revised and updated this program to include three separate age range BASIC programs: the baby/toddler age (0–3 years), preschool (3–5 years), and school-age (6–13 years). Each of these revised programs include age appropriate examples of culturally diverse families, children with varying temperaments, and added emphases on social and emotional coaching, problem solving, how to set up predictable routines, and support children's academic success. The BASIC toddler parent training programs are completed in 12 weekly, 2 hour sessions while the preschool and school-age programs are 18–20 weekly, 2 hour sessions. The foundation of the program is brief video vignettes of modeled parenting skills (each program has over 300 vignettes) shown by a therapist to groups of 8–12 parents. The videos demonstrate social learning and child development principles and serve as the stimulus for focused discussions, problem solving, and collaborative learning. The program is also designed to help parents understand normal variations in children's development, emotional reactions, and temperaments.

The BASIC program begins with a focus on enhancing positive relationships between parents and children by teaching parents to use child-directed interactive play, academic and persistence coaching, social and emotional coaching, praise, and incentive programs. Next, parents learn how to set up predicable home routines and rules, followed by learning a specific set of nonviolent discipline techniques including monitoring, ignoring, commands, natural and logical consequences, and ways to use time-out to teach children to calm down. Finally, parents are taught how they can teach their children problem-solving and self-regulation skills.

ADVANCE parent training treatment program. In 1989, we expanded our theoretical and causal model concerning conduct problems and developed the ADVANCE treatment program (updated in 2008). This program was designed to be offered after parents complete the BASIC parenting program and focuses on helping parents with adult intra- and interpersonal skills. The content of this 10–12-session video program (over 90 vignettes) consists of five components: (a) personal self-control, anger management, positive self-talk, and other coping strategies; (b) communication skills for talking effectively with partners, teachers, and other adults; (c) problem-solving conflict situations with partners, extended family members, teachers, and employers; (d) problem solving with children and conducting family meetings; and (e) strengthening social support and self care. We theorized that a broader-based training model would help mediate the negative influences

of these personal and interpersonal factors on parenting skills and promote increased maintenance and generalizability of treatment effects.

The content of both the BASIC and ADVANCE programs is also provided in the recently revised text that parents use for the program, titled *The Incredible Years: A Troubleshooting Guide for Parents* (Webster-Stratton, 2006)

SCHOOL parent training treatment. More than 50% of parents who completed our parent training programs requested guidance on issues surrounding homework, communication with teachers, behavior problems at school, and promoting their children's academic and social skills. In addition, 40% of teachers reported problems with children's compliance and aggression in the classroom and requested advice on how to manage these problems. Clearly, integrating interventions across settings (home and school) and agents (teachers and parents) to target school and family risk factors fosters greater between-environment consistency and offers the best chance for long-term reduction of antisocial behavior.

In 1990, we developed an academic skills training intervention (SCHOOL) as an adjunct to our school-age BASIC program, and in 2003, a school readiness intervention as an adjunct to our preschool BASIC program. These two interventions each consist of four to six additional sessions usually offered to parents after the BASIC program is completed. For parents of school-age children, these sessions focus on collaboration with teachers, ways to foster children's academic readiness and school success through parental involvement in school activities and homework, and the importance of after-school and peer monitoring. For the parents of preschool children, the sessions focus on interactive reading skills and ways to promote children's social, emotional, self-regulation, and cognitive skills. Program components include teaching parents to: (a) help children feel confident in their own ideas and ability to learn; (b) prepare children for school by facilitating pre-reading skills (pre-school) and supporting/encouraging older children with homework routines and limits on "screen time"; (c) support children's discouragement and learning difficulties by setting realistic goals, encouraging their persistence with difficult tasks, and using academic coaching to motivate and reinforce learning progress at home; and (d) collaborate with teachers to jointly develop plans that address behavioral issues at school.

Incredible Years Teacher Training Intervention

When children with behavior problems enter school, negative academic and social experiences escalate the development of conduct problems. Aggressive, disruptive children quickly become socially excluded, and peers begin to respond to aggressive children in ways that increase the likelihood of reactive aggression. This peer rejection leads to association with deviant peers, which increases the risk for higher levels of antisocial behavior. In addition, teacher behaviors (low rates of praise, high rates of critical/harsh discipline, ineffective management strategies, low emphasis on teaching social–emotional competence) and classroom/school

characteristics (high student–teacher ratio, no tolerance school discipline policies, high classroom levels of children with special needs) are associated with increased aggression, delinquency, and poor academic performance. Rejecting and non-supportive responses from teachers further exacerbate the problems of aggressive children.

In 1995 (revised 2003), we developed a 6-day (42 h) teacher-training program with the goal of promoting teacher competencies and strengthening home–school connections by doing the following: (a) improving teachers' classroom management skills, including proactive teaching approaches and effective discipline; (b) increasing teachers' use of academic, persistence, social, and emotional coaching with students; (c) strengthening teacher–student bonding; (d) improving home–school collaboration and parent–teacher bonding; and (e) increasing teachers' ability to teach social skills, anger management, and problem-solving skills in the classroom. A complete description of the content included in this curriculum is described in the book that teachers use for the course, titled *How to Promote Social and Emotional Competence* (Webster-Stratton, 2000).

Incredible Years Child Training Intervention (Dinosaur School)

Research has indicated that children with conduct problems are more likely to have certain temperamental characteristics such as inattentiveness, distractibility, impulsivity, and ADHD. Other child factors have also been implicated in early-onset CD. For example, deficits in social–cognitive skills and negative attributions contribute to poor emotional regulation and aggressive peer interactions. In addition, studies indicate that children with conduct problems have significant delays in their peer-play skills – in particular, difficulty with reciprocal play, cooperative skills, taking turns, waiting, and giving suggestions (Gottman, 1983; Webster-Stratton & Lindsay, 1999). Finally, reading, learning, and language delays are also associated with conduct problems, particularly for "early life course persisters" (Moffitt & Lynam, 1994). Academic difficulties and behavior problems exacerbate one another in a bidirectional spiral whereby academic problems lead to disengagement, increased frustration, and lower self-esteem, which contribute to the child's behavior problems. At the same time, negative classroom behavior limits a child's ability to be engaged in learning, to follow teacher's instructions, and to achieve academically. Thus, a cycle is created in which one problem exacerbates the other. This combination of academic delays and conduct problems contributes to the development of more severe CD and school failure.

In 1990, we developed a child treatment program to directly focus on the social learning and academic deficits of children diagnosed with ODD or conduct problems (ages 4–8). This 22-week program (revised 2006) consists of a series of DVD programs (over 180 vignettes) that teach children problem solving and social skills. Organized to dovetail with the content of the parent-training program, the program consists of seven main topic areas: Introduction and Rules; Empathy and Emotion; Problem Solving; Anger Control; Friendship Skills; Communication Skills; and School Skills.

The children meet weekly in groups of six children for 2 h. To enhance generalization, the video vignettes involve real-life conflict situations at home and at school (playground and classroom), such as teasing, being rejected, and destructive behavior. The goals of this program are to promote children's competencies and reduce aggressive and noncompliant behaviors by doing the following: (a) strengthening social skills (turn taking, waiting, asking, sharing, helping, and complimenting); (b) promoting use of self-control and self-regulation strategies; (c) increasing emotional awareness by labeling feelings, recognizing the differing views of oneself and others, and enhancing perspective taking; (d) promoting children's ability to persist with difficult tasks; (e) improving academic success, reading, and school readiness; (f) reducing defiance, aggression, peer rejection, bullying, stealing, lying, and promoting compliance with teachers and peers; (g) decreasing negative cognitive attributions and conflict management approaches; and (h) increasing self-esteem and self-confidence.

Group Process and Methods Used in Parent, Teacher, and Child Training Programs

All three treatment approaches rely on performance training methods and group support training including video modeling, role play, practice activities, and live feedback from the therapist and other group members. In accordance with modeling and self-efficacy theories of learning, parents, teachers, and children participating in the program develop their skills by watching video examples of key skills, discussing and sharing their reactions to the videos, and then modeling or role playing skills themselves. Video examples provide a more flexible method of group training than didactic verbal instruction or sole reliance on role play because a wide variety of models, settings, and situations can be used as examples. The goals of this approach are to provide better generalization of the content and, therefore, better long-term maintenance; to provide a variety of learning methods – visual, verbal, and performance; to be low-cost because of the group format; and easily disseminated because of the extensive videos and manuals.

The video vignettes show parents, teachers, and children of differing ages, cultures, socioeconomic backgrounds, temperaments and developmental abilities, so that participants will perceive at least some of the models as similar to themselves and will therefore accept the vignettes as relevant. Vignettes show models (unrehearsed) in natural situations responding effectively as well as times when they are responding less effectively in order to demystify the notion that there is "perfect parenting or teaching" and to illustrate how one can learn from one's mistakes. This approach also emphasizes our belief in a coping and collaborative interactive model of learning (Webster-Stratton & Herbert, 1994); that is, participants' view a video vignette of a situation and then discuss and role play how the individual might have handled the interaction more effectively. Thus participants improve upon the interactions they see in the vignettes. This approach enhances participants' confidence and develops their ability

to analyze interpersonal situations and select an appropriate response. In this respect, our training differs from some training programs where the therapist provides the analysis and recommends a particular strategy.

The video vignettes demonstrate behavioral principles and serve as the stimulus for focused discussions, problem solving, and collaborative learning. After each vignette, the therapist solicits ideas from group members and involves them in the process of problem solving, sharing, and discussing ideas and reactions. The therapists' role is to support and empower group members by teaching, leading, reframing, predicting, identifying key developmental or teaching principles, and role playing (Webster-Stratton & Hancock, 1998). The collaborative context is designed to ensure that the intervention is sensitive to individual cultural differences and personal values. The program is "tailored" to each teacher, parent, or child's individual needs and personal goals as well as to each child's personality and behavior problems.

This program also emphasizes a commitment to group members' self-management. We believe that this approach empowers participants in that it gives back dignity, respect, and self-control to parents, teachers, and children who are often seeking help at time of low self-confidence and intense feelings of guilt and self-blame (Webster-Stratton, 1996). By using group process, the program not only is more cost-effective but also addresses an important risk factor for children with conduct problems; the family's isolation and stigmatization. Parent groups provide that support and become a model for parent support networks (see Webster-Stratton & Herbert, 1994.) The child groups provide children with conduct problems some of their first positive social experiences with other children. Moreover, it was theorized that the group approach would provide more social and emotional support and decrease feelings of isolation for teachers as well as parents and children.

As with the teacher and parent programs, the child treatment program uses video modeling examples in every session to foster discussion, problem solving, and modeling of prosocial behaviors. The scenes selected for each of the units involve real-life conflict situations at home and at school (playground and classroom). The videotapes show children of differing ages, sexes, and cultures interacting with adults or with other children. After viewing, the vignettes, children discuss feelings, generate ideas for more effective responses, and role play alternative scenarios. In addition to the interactive video vignettes, the therapists use life-size puppets to model appropriate behavior and thinking processes for the children. The use of puppets appeals to children on the fantasy level so predominant in this preoperational age group. Because young children are more vulnerable to distraction, are less able to organize their thoughts, and have poorer memories, we use a number of strategies for reviewing and organizing the material, such as: (a) playing "copy cat" to review skills learned; (b) using many video examples of the same concept in different situations and settings; (c) using cartoon pictures and specially designed stickers as "cues" to remind children of key concepts; (d) role playing with puppets and other children to provide practice opportunities and experience with different perspectives; (e) reenacting video scenes; (f) rehearsing skills with

play, art, and game activities; (g) homework, so children can practice key skills with parents; and (h) letters to parents and teachers that explain the program's key concepts and asking them to reinforce these behaviors.

EVIDENCE FOR THE EFFECTS OF TREATMENT

Effects of Parent Training Program

The efficacy of the IY BASIC parent treatment program for children (ages 3–8 years) diagnosed with ODD/CD has been demonstrated in six published randomized control group trials by the program developer and colleagues at the University of Washington Parenting Clinic (Reid, Webster-Stratton, & Hammond, 2007; Webster-Stratton, 1981; Webster-Stratton, 1982, 1984, 1990a, 1992, 1994, 1998; Webster-Stratton & Hammond, 1997; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton, Reid, & Hammond, 2004). In all of these studies, the BASIC program has been shown to significantly improve parental attitudes and parent–child interactions, and significantly reduce harsh discipline, and child conduct problems compared to wait-list control groups and other treatment approaches. In the third of these studies, treatment component analyses indicated that the combination of group discussion, a trained therapist, and video modeling produced the most lasting results in comparison to treatment that involved only one training component (see Webster-Stratton, Hollinsworth, & Kolpacoff, 1989, and Webster-Stratton, Kolpacoff, & Hollinsworth, 1988).

In addition, the BASIC program has been replicated in five projects by independent investigators in mental health clinics with families of children diagnosed with conduct problems (Drugli & Larsson, 2006; Larsson et al., 2008; Lavigne et al., 2008; Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Spaccarelli, Cotler, & Penman, 1992; Taylor, Schmidt, Pepler, & Hodgins, 1998). These replications were "effectiveness" trials; that is, they were done in applied mental health settings, not a university research clinic, and the therapists were typical therapists at the centers not research therapists. Three of the above replications were conducted in the United States, two in United Kingdom, and one in Norway. This illustrates the transportability of the BASIC parenting program to other cultures.

In our fourth study, we examined the effects of adding the ADVANCE intervention (parent intra- and interpersonal skills) component to the BASIC intervention (Webster-Stratton, 1994) by randomly assigning families to either BASIC parent training or BASIC + ADVANCE training. Both treatment groups showed significant improvements in child adjustment and parent–child interactions and a decrease in parent distress and child behavior problems. These changes were maintained at follow-up. ADVANCE children showed significant increases in the number of prosocial solutions generated during problem solving, in comparison to children whose parents received only the BASIC program. Observations of parents' marital interactions indicated significant improvements in ADVANCE parents' communication, problem-solving, and collaboration skills when compared

with parents who did not receive ADVANCE. Moreover, ADVANCE parents reported significantly greater consumer satisfaction than parents who did not receive ADVANCE. These results suggest that focusing on helping parents to manage personal distress and interpersonal issues through a video modeling group discussion treatment (ADVANCE) added significantly to treatment outcomes for our BASIC program. Consequently, a 20–24-week program that combines BASIC with ADVANCE has become our core treatment for parents with children with conduct problems.

In our sixth and seventh studies respectively, we examined the additive effects of combining the child training intervention (Dinosaur School) and teacher training with the parent training program (BASIC + ADVANCE). Both studies replicated positive results from the ADVANCE study and provided data on the advantages of training children and teachers as well as parents. (Study results are presented below, see section on Effects of Teacher- and Child-Training Treatment and Prevention Programs.)

Parent training treatment: Who benefits and who does not? We have followed families longitudinally (1, 2, and 3 years post treatment), and have completed a 10–15-year follow-up of the children and their families. We assessed both the statistical and clinical significance of treatment effects. In assessing clinical significance, we looked at the extent to which parent or teacher reports indicated that the children were within the nonclinical range of functioning or showed a 30% improvement if there were no established normative data, and whether families requested further therapy for their children's behavior problems at the follow-up assessments. These outcome criteria were chosen to avoid reliance on a single informant or criterion measure, thereby providing greater validity to the findings. In our 3-year follow-up of 83 families treated with the BASIC program, we found that while approximately two-thirds of children showed clinically significant behavior improvements, 25–26% of parents and 26% of teachers still reported clinically significant child behavior problems (Webster-Stratton, 1990b). We also found that the families whose children had continuing externalizing problems (according to teacher and parent reports) at our 3-year follow-up assessments were more likely to be characterized by marital distress or single-parent status, maternal depression, lower social class, high levels of negative life stressors, and family histories of alcoholism, drug abuse, and spouse abuse (Webster-Stratton, 1990b; Webster-Stratton & Hammond, 1990).

Hartman (Hartman, Stage, & Webster-Stratton, 2003) examined whether child ADHD symptoms (i.e., inattention, impulsivity, and hyperactivity) predicted poorer treatment results from the parent-training intervention. Contrary to Hartman's hypothesis, analyses suggested that the children with ODD/CD who had higher levels of attention problems showed *greater* reductions in conduct problems than children without attention problems. Similar findings for children with ADHD were reported in the UK study (Scott et al., 2001). An ongoing study is evaluating the parent and child treatments with young children whose primary diagnosis is ADHD.

Webster-Stratton et al. (in press) conducted an 8- to 12-year follow-up of families who were in the ADVANCE study previously discussed. She

interviewed 83.5% of the parents and adolescents from the original study (now 12–19 years of age). Results indicated that over 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems. Furthermore, parenting skills taught in the intervention had lasting effects. Important predictors of long-term outcome were mothers' post-treatment level of critical statements and fathers' use of praise. In addition, the level of mother–child coercion immediately post treatment was a significant predictor of teen adjustment.

Evidence for Effects of Parent Programs as Prevention

In the past decade, we have also evaluated the parent programs as a selective prevention program with multiethnic, socioeconomically disadvantaged families in two randomized studies; one with low income Head Start families and another with unselected primary school children. Results of all these studies suggest the program's effectiveness as a method of preventing the development of conduct problems and strengthening social competence in preschool children (Reid, Webster-Stratton, & Hammond, 2007; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001). These studies also showed that programs were equally effective for families from diverse cultural and ethnic backgrounds including Latino, Asian, and African American families. (Reid, Webster-Stratton, & Beauchaine, 2001). The study with primary school children evaluated the effects of the parent intervention with an indicated, culturally diverse population. Children who received the intervention showed fewer externalizing problems, better emotion regulation, and stronger parent–child bonding than control children. Mothers in the intervention group showed more supportive and less coercive parenting than control mothers (Reid, Webster-Stratton, & Hammond, 2007). Similar results were reported by independent investigators with selective and indicated prevention populations including a study conducted in the United Kingdom (Gardner, Burton, & Klimes, 2006; Gross et al., 2003; Hutchings & Gardner, 2006; Miller Brotman et al., 2003). One study reported the effectiveness of the IY parent program with foster parents (Linares, Montalto, MinMin, & Oza, 2006).

Summary and significance. Over the past 28 years, studies have shown that parent training is a highly effective therapeutic method for producing significant behavior change in children with conduct problems and with high-risk populations (i.e., socioeconomically disadvantaged). These findings provide support for the notion that parenting practices play a key role in children's social and emotional development.

Effects of Teacher- and Child-Training Treatment and Prevention Programs

To date, there have been two randomized studies by the developer and one by an independent evaluator evaluating the effectiveness of the child-training program for reducing conduct problems and promoting social

competence in children diagnosed with ODD/CD. In the first two studies (Drugli & Larsson, 2006; Webster-Stratton & Hammond, 1997), clinic-referred children (with ODD) and their parents were randomly assigned to one of four groups: a parent-training treatment group (PT), a child-training group (CT), a child- and parent-training group (CT + PT), or a waiting-list control group (CON). Post-treatment assessments indicated that all three treatment conditions resulted in significant improvements in parent and child behaviors in comparison to controls. Comparisons of the three treatment conditions indicated that CT and CT + PT children showed significant improvements in problem solving as well as conflict management skills, as measured by observations of child interactions with a best friend; differences among treatment conditions on these measures consistently favored the CT conditions over the PT only condition. On measures of parent and child behavior at home, PT and CT+ PT parents and children had significantly more positive interactions in comparison to CT parents and children.

One-year follow-up assessments indicated that all the significant changes noted immediately post treatment were maintained over time. Moreover, child conduct problems at home significantly decreased over time. Analyses of the clinical significance of the results suggested that the combined CT + PT condition produced the most significant improvements in child behavior at 1-year follow-up. However, children from all three treatment conditions showed increases in behavior problems at school 1 year later, as measured by teacher reports (Webster-Stratton & Hammond, 1997).

Another study (Webster-Stratton, Reid, & Hammond, 2004) tested the effects of different combinations of parent, child, and teacher training. Families with a child diagnosed with ODD were randomly assigned to one of six groups: (a) Parent training only; (b) Child training only; (c) Parent training and teacher training; (d) Parent training, teacher training, and child training; (e) Child training and teacher training; or (f) Waitlist control.

As expected, results for the parent training component replicated earlier studies with parents in all three conditions that received parent training showing significantly less negative and more positive parenting than parents in conditions that did not receive training (Webster-Stratton & Reid, 1999). Children in all five treatment conditions showed reductions in aggressive behaviors with mothers at home, and at school with peers and teachers, compared with controls. Treatment effects for children's positive social skills with peers were found only in the three conditions with child training compared with controls. Trained teachers were rated as less critical, harsh, and inconsistent, and more nurturing than control teachers. Most treatment effects were maintained at 1-year follow-up. In summary, this study replicated our previous findings on the effectiveness of the parent- and child-training programs and indicated that teacher training significantly improves teachers' classroom management skills and improves children's classroom aggressive behavior. In addition, treatment combinations that added either child training or teacher training to the parent training were most effective.

Three other randomized control group studies (Raver et al., 2007; Webster-Stratton, Reid, & Hammond, 2001; Williford & Shelton, 2008) have evaluated the teacher-training curriculum in a prevention setting with Head Start teachers. In the study by the developer, parent–teacher bonding was reported to be significantly higher for experimental than for control mothers. Experimental children showed significantly fewer conduct problems at school than control children, and trained teachers showed significantly better classroom management skills than control teachers. In the second study by an independent investigator (Raver et al., 2007) 5 days of the IY Teacher Program were delivered to teachers in combination with weekly visits by mental health consultants who "coached" teachers as they implemented management strategies. Results showed that Head Start classrooms in the treatment condition had significantly higher levels of positive classroom climate, teacher sensitivity and behavior management than classrooms in the control condition with medium to high effect sizes.

Lastly, a recent study (Webster-Stratton, Reid, & Stoolmiller, 2008) was completed using the teacher training and classroom Dinosaur curriculum in Head Start and with primary schools that serve high numbers of economically disadvantaged children. Results showed significant improvements in conduct problems, self-regulation, and social competence compared with control students. Effect size was particularly high for children with high baseline levels of conduct problems. Another prevention study using the curriculum in schools reported reductions in playground aggressive behavior compared to control schools (Barrera et al., 2002).

Who benefits from Dinosaur child training? Analyses on 99 children diagnosed with ODD who received child treatment were conducted to examine the effects of child hyperactivity, parenting style, and family stress on treatment outcome. The hyperactivity or family stress risk factors did not have an impact on children's treatment response. Negative parenting, on the other hand, did negatively impact children's treatment outcome. Fewer children who had parents with one of the negative parenting risk factors (high levels of criticism or physical spanking) showed clinically significant improvements compared to children who did not have one of the negative parenting risk factors. This finding suggests that for children whose parents exhibit harsh and coercive parenting styles, it is important to offer a parenting intervention in addition to a child intervention (Webster-Stratton, Reid, & Hammond, 2001). Our studies also suggest that child training significantly enhances the effectiveness of parent training treatment for children with pervasive conduct problems (home and school settings) because of its added benefits for children's classroom peer interactions and social competence.

CASE EXAMPLE: STEWART

The following section presents a case in which the IY Parent, Teacher, and Child Training Programs were used to treat a young boy, Stewart. Stewart is a 6-year-old who presented with ODD and ADHD. His problems

occurred at home, at school, and with peers. This case study outlines how the three different IY Programs (parent, teacher, and child) can be applied flexibly and synergistically to attend to individual family needs and address issues of comorbidity.

INTAKE INFORMATION

Susan and Tim Jones were referred to the Parenting Clinic by their school psychologist because of difficulties at home and at school with their 6-year-old son, Stewart. Stewart had a substantial reputation at the school for his aggressive and oppositional behavior. At the time that the Joneses came to the clinic, his teacher had told his parents that she did not believe her classroom was an appropriate place for Stewart. In addition to these problems at school, Stewart's behavior at home was extremely volatile. He would frequently "lose control of his behavior" and engage in extended temper tantrums during which he would call his parents names, refuse to comply with any requests, and become aggressive or destructive. Both parents described feeling helpless to change Stewart's behavior once it reached these proportions. Their usual parenting style was to talk and reason with Stewart, but they felt that this merely escalated his behavior. They also had tried a number of different discipline strategies (e.g., time-out, loss of privileges), that did not seem to work to change Stewart's behavior. Susan and Tim were also concerned about the effect that his difficulties were having on his self-esteem. Stewart had begun talking about the fact that no one liked him at school, that he had no friends, and that he was the dumbest kid in his class. Lastly, Susan and Tim reported that Stewart's behaviors were putting a significant strain on the family's functioning. Both felt his problems were their main focus, to the exclusion of other activities and interests. They felt that they no longer had control over their family and were worried that Stewart's behavior was on an irreversible trajectory.

TREATMENT

Treatment began in October, following the assessment period. Stewart and his parents came to the University of Washington Parenting Clinic each week for a 2 h group that lasted 24 weeks. During that time, Stewart attended the child group with five other children (three boys and two girls, ages 4–7), and his parents attended the parenting group.

Parent group. During the initial group, parents described their children and their reasons for coming to the clinic. Many of the parents, and Susan, in particular, described how isolated she felt as a parent of a "problem child." She felt that they could no longer socialize with their friends because Stewart was not able to behave appropriately. She felt judged by other parents and felt that she was a bad parent because nothing she did worked with Stewart. Tim expressed a sense of relief at being in a group

where he was free to talk about his son's issues without judgment from other parents. Susan and Tim expressed goals for Stewart primarily in terms of his happiness and self-esteem, although they believed that to achieve these goals, they would need to find ways to reduce his oppositional behavior, improve his social skills, and increase his cooperation with authority.

The first four to five sessions of the group were focused on child-directed play interactions. Since almost all adult–child interactions with Stewart involved a power struggle, and since his negative behaviors had placed such great strain on the parent–child relationship, the first goal of therapy was to use child-directed play to begin to change the dynamic of this relationship. Tim and Susan were encouraged to play with Stewart on a daily basis where their job was to follow Stewart's lead, be an "appreciative audience," and not to make demands, give instructions or even ask questions as long as he was appropriate in his behavior. These play sessions were designed to give Stewart some power in the relationship in an appropriate setting, to show him that his parents valued him, and to give his parents a time when they could just enjoy his creativity and playfulness without feeling as if they had to make him behave in a certain way. At first, Tim and Susan reported that he rejected their attempts to play with him. They were encouraged to be persistent and to make regular attempts each day to engage with him in this positive way. Gradually Stewart began to look forward to this time playing with his parents and seemed excited that they were willing to play on his terms. Although much of Stewart's behavior outside of the play sessions continued to be negative and challenging, Stewart's parents reported that he seemed calmer after play sessions, and that they had moments of feeling connected and appreciative of his strengths. They gradually also began to address some of Stewart's ADHD behaviors during these play sessions by using focused persistence coaching to comment when they saw Stewart being persistent, calm, or patient with an activity. For example, they learned to say such things as, "You are really concentrating and working hard on that puzzle, you just keep trying and are going to figure it out."

As these play sessions became more enjoyable, parents were taught to use social and emotion coaching with him one-on-one. This coaching helped him to develop emotional literacy, to express his feelings rather than to strike out at someone when frustrated. He also was helped to use social skills by coaching him when he was sharing, waiting, helping, and taking turns.

The ignoring and limit setting units were challenging for Tim and Susan. Both were used to reasoning with Stewart when he was misbehaving. They understood the principle of ignoring when Stewart was annoying or verbally abusive; however, they had difficultly following through. Stewart was very persistent with his whining and tantrums, and both parents needed support and encouragement to stick to their discipline plans. Stewart frequently swore and called his parents names, which they found difficult to ignore. When they did ignore, he would also cry and yell that they didn't love him and would then become very destructive. Strategies to help Tim and Susan involved teaching them to use calming self-talk (e.g., " I can stay

calm, I can handle this") and reframing strategies (e.g., "He will feel safer when he learns there are predictable limits"). They had tried using time-out but had always given up part way through the process because of Stewart's aggressive and destructive behavior. Group problem solving helped them to plan ways to keep Stewart and the house safe during a destructive time-out. All of these solutions were role played with the group so that Tim and Susan felt equipped to try them out at home and prepared for his oppositional responses. With this support, they managed to successfully complete several lengthy time-out sequences with Stewart. There was a marked shift in their self-confidence after this point. Although Stewart continued to have very difficult days, they felt more equipped to handle his behavior at home. They also noticed that the frequency of these very intense tantrums decreased markedly.

The adult communication and problem-solving material was also useful to Tim and Susan. They had a strong relationship; however, their focus on Stewart was so all-consuming and so reactive that they rarely spent time communicating about their plan for working together to manage his behavior. Consequently, they sometimes had difficulty backing each other up because they hadn't agreed in advance about how to handle a problem. The communication and problem-solving sections of the curriculum helped them to set aside time to make proactive plans for managing family issues, as well as helping them realize that they also needed some time for themselves to reconnect on adult issues.

Working with the school and teacher training. Although Susan and Tim grasped the concepts in the parenting group and worked hard to implement new strategies at home, they were experiencing significant conflict with the school. Even after Stewart's behavior began to improve at home, it continued to worsen at school. His teacher repeatedly requested that he be removed from her classroom, and Stewart was so unhappy at school that it became a battle to get him to school in the mornings. Susan and Tim received daily negative reports about Tim's behavior. Tim, Susan, and Stewart's teacher and principal were all frustrated, and the parent–school relationship had become quite adversarial. Tim and Susan reported that whenever they met with the principal and the teachers, they felt personally attacked, and felt responsible for defending Stewart, even though they agreed that his behavior had been unacceptable.

Although Stewart's teacher was not happy about having him in her class, she did agree to attend 4 days of teacher training at the clinic. This training gave her a chance to express her frustration with the classroom situation and to share ideas with other teachers who also had challenging students. She reported that she had a class of 25 children, five of whom had special needs. Stewart's behavior was the most severe, and, in her opinion, he frequently set off her other challenging children so that she felt unable to manage the situation. Through a series of parent–teacher conferences, a meeting with the principal, and support from other teachers during the teacher training as well as help from the therapists, things slowly began to improve. Stewart's parents, teacher, and the IY therapists worked collaboratively to set up a simple behavior plan for Stewart in the classroom. This plan focused on a few positive behavioral goals with frequent

reinforcement, a wiggle space for times when Stewart was having difficulty sitting still, and a back-up time-out plan for severe negative behavior. Stewart was able to earn breaks for successfully completing manageable parts of his school work. He was also given sanctioned reasons to move around the classroom since it was difficult for him to sit still for long periods of time. Peer issues were also addressed. His teacher made a concerted effort to highlight Stewart's strengths to the class. As part of his behavior plan, he was able to earn chances to assist other children (an activity that had proven to be very reinforcing to him in our child Dinosaur group at the clinic). On the playground, Stewart was initially limited to activities in a smaller, well-supervised area, and through appropriate behavior was able to earn the privilege of expanded recess. Lastly, Stewart was also referred for a special education evaluation, which eventually led to a part-time classroom assistant who was able to relieve some of the pressure on his teacher.

Child dinosaur social skills and problem solving group. Stewart was initially resistant to the idea of coming to the child groups. His negative experience with school made him extremely reluctant to participate in any activity that seemed remotely like school. During the first few sessions, the therapists had the puppets model that they, too, had been scared or mad when they first came to Dinosaur school, but that they soon started to like the group and had made good friends. After this initial processing, the therapists ignored Stewart's complaints about being in the group and instead focused on praising and giving tokens for any appropriate behavior that he exhibited. They noticed that while he was reluctant to volunteer answers or participate on his own, if he was asked to help another child with an answer or a project, he quickly became involved. Initially Stewart sought attention from the other children in the group by being disruptive and inappropriate. The other children were taught to ignore this inappropriate behavior. Stewart was also put in charge of helping to monitor other children's friendly and positive behavior. This provided him with an opportunity to receive attention and positive approval from others. After four sessions, Stewart began to report to his parents that he liked Dinosaur school. Two of the other boys in the group became friends with Stewart, and they began to have some play dates after school. From this point on, Stewart was consistently positive about coming to the group, and his parents reported that he seemed happy about a group peer activity for the first time in his life.

A second issue for Stewart during the child groups was difficulty sitting and attending for more than a few minutes at a time. The therapists arranged the format of the group such that children had frequent opportunities to change activities and move around. After showing the children a video vignette, therapists would lead a brief discussion with the puppet and then have children role play the situation. They continually interspersed sedentary activities with more active rehearsal and "hands-on" learning. Stewart was reinforced for attentive behavior, but the therapist also ignored considerable wiggling and movements, if he was engaged in the lesson. Stewart was also allowed to leave the group and go to a "wiggle space" if he was unable to sit still. As long as the activities changed

frequently and the therapists monitored Stewart's attention level and need to move around, they were able to keep him engaged and on-task.

Social, persistence, and emotion coaching were also an important part of Stewart's treatment plan. In order to gradually increase Stewart's ability to focus and concentrate on a given activity, therapists worked hard to identify times when Stewart was focused, calm, working hard, working carefully, and sticking with an activity. They noticed that Stewart's attention span was immediately longer whenever descriptive commenting was used, most likely because he enjoyed the attention and wanted it to continue. This provided many opportunities to comment on his persistence. Since Stewart was also easily dysregulated and quick to get angry, attention was given to times when he was calm, regulated, and content. When Stewart started to become angry, his feelings were labeled, and then the therapist predicted that he would be able to stay calm and try again (if he tantrumed, he was ignored.) Stewart's social behaviors were also encouraged through a combination of descriptive commenting, modeling, and coaching. If Stewart spontaneously engaged in a friendly behavior, the therapists' labeled that behavior: e.g., "Wow, Stewart, you just asked for that block in a friendly voice." At times, they also modeled a behavior themselves (or used a puppet to model the behavior). "Stewart, I've got an extra train car. I would like to share it with you." They also provided direct coaching to Stewart when they saw he wanted something but was not expressing himself. "Stewart, it looks like you're frustrated that you don't have more train track. Can you ask Dylan if he will let you use some more pieces?"

Summary of treatment. Stewart's behavior improved at home as Susan and Tim begin to use more effective limit setting, combined with frequent positive interactions and coaching his social behaviors. There continued to be explosive incidents throughout the treatment period, but they became less frequent, and Susan and Tim became confident in their ability to handle the problems. The Dinosaur child group quickly became a reinforcing activity for Stewart, and he made some of his first friends in the group and was proud of these interactions. This was in sharp contrast to his negative feelings about peers and school. He also learned specific social and problem-solving skills that he began to use with peers in social situations. School changes were most difficult, but parents, teachers, and therapists all worked hard to continue to implement new strategies there. Stewart's difficult behavior and explosive episodes at school continued, but were reported to be less frequent and less intense. In addition, the school and the teacher began to feel equipped to handle the behaviors and they worked collaboratively with Stewart's parents to set goals and modify his behavior plan as needed.

NEW PROGRAMS

In recent years, the IY parent programs (BASIC) have been extended to include new programs for older children (8–13 years) as well as infants (0–12 months) and toddlers (1–3 years). Current studies are in progress to

evaluate the effectiveness of these programs. The intervention model for these two programs is similar to all of our other programs and includes video vignettes of families and their young children. Below is a summary of the content for each program.

BABY-TODDLER program. The new BABY-TODDLER curriculum is split into two programs. The first program covers the baby 0–12 months of age and can be completed in 8–10 sessions (the toddler program is delivered in 18 sessions and is described above). The content of the Baby Program includes: (a) getting to know your baby; (b) parents as responsive communicators and babies as intelligent language learners; (c) providing physical and visual stimulation for your baby; (d) learning to read babies' minds; (e) gaining support; and (f) the emerging sense of self. Parents attend these groups with their babies and participate in hands-on role plays and exercises with their own babies. Pilot groups are currently being run in Seattle with parents referred by the child welfare system and in Wales with low-income families. Preliminary clinical reports show that these groups are well evaluated by parents; attendance and satisfaction ratings have been very high in both pilot programs.

SCHOOL-AGED program. The new SCHOOL-AGED curriculum for 8–13 year olds consists of 16–18 sessions. New vignettes for this age group include: (a) special time and projects; (b) social, emotional and persistence coaching; (c) encouraging home responsibilities; (d) rules and discussions regarding computer and TV use, and drugs and alcohol; (e) following through with rules; (f) selective ignoring and avoiding arguments; and (g) imposing consequences. The first 12 weeks focus on social and emotional skills and home behavior followed by four sessions in which parents learn how to encourage and support their child's academic competence. This includes promoting reading habits, helping children with homework assignments, fostering good learning habits and routines, and working with schools. It is highly recommended that the ADVANCE program with its focus on problem solving and family meetings is also delivered in conjunction with the BASIC program, especially when working with parents of antisocial children. Over the past year, this program has been evaluated in England with severely antisocial children ages 9–13 years. Preliminary results show high parent evaluations by parents as well as high program attendance.

DIRECTIONS FOR FUTURE RESEARCH

Although our programs were first designed and evaluated to be used as clinic-based treatments for diagnosed children and their parents and teachers, our more recent evaluations have shown the programs to be equally effective in preventive settings with high-risk families and children. This prevention model has allowed us to research our intervention with families who might not seek or receive mental health services in traditional clinic settings, and also with at-risk children before their behaviors have reached clinical levels.

As more is known about the type, timing, and dosage of interventions needed to prevent and treat children's conduct problems, we can further

target children and families to offer treatment and support at strategic points. By providing a continuum of services we believe we will be able to prevent the further development of CDs, delinquency, and violence. For example, the prevention versions of the classroom social skills intervention, parent training, and/or teacher training might be offered as universal prevention to all children in a school. Children who continue to exhibit significant behavior problems might be offered the treatment versions of the programs. For those children requiring additional treatment, more research is needed to understand what constellation of treatments (parent, teacher, child) would best fit their particular needs.

Ongoing research is evaluating the IY programs with new populations including neglectful and abusive families referred by Child Protective Services, children with ADHD, and families from many different countries around the world including Russia, Turkey, Australia, Holland, and Scandinavia.

SUMMARY AND CONCLUSIONS

In summary, a review of our research suggests that interactive video training methods are effective treatments for early-onset ODD/CD. Our most effective parent intervention includes both parenting skills and training in marital communication, problem solving and conflict resolution, and ways to foster children's academic and social emotional competence. These findings document the need for interventions that strengthen families' protective factors (specifically, parents' interpersonal skills and coping skills) so that they can cope more effectively with the added stress of having a child with conduct problems. Our research has also suggested that child and teacher training are highly effective strategies for addressing children's social deficits and improving social skills, problem-solving strategies, and peer relationships. The addition of child or teacher training seems to be particularly helpful for children with pervasive conduct problems (school and home) and with peer relationship difficulties.

Our intervention studies, which target different combinations of risk factors, can be seen as an indirect test of the different theoretical models regarding the development of CDs. We started with a simple parenting skills deficit model and have evolved to a more complex interactional model. In our current model, we hypothesize that the child's eventual outcome will be dependent on the interrelationship between child, parent, teacher, and peer risk factors. Therefore, the most effective interventions should be those that involve schools, teachers, and the child's peer group as well as parents.

ACKNOWLEDGEMENTS

This research was supported by the NIMH Research Scientist Development Award MH00988, NIMH 5 R01 MH067192, and 5 R01 MH074497. Correspondence concerning this chapter should be addressed to Carolyn Webster-Stratton, University of Washington, School of Nursing, Parenting Clinic, 1141 8th Avenue West, Seattle, WA 98119. The senior author of

this paper has disclosed a potential financial conflict of interest because she disseminates these interventions and stands to gain from a favorable report. Because of this, she has voluntarily agreed to distance herself from certain critical research activities (i.e., recruiting, consenting, primary data handling, and analysis), and the University of Washington has approved these arrangements.

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