

9

TREATING CHILDREN WITH EARLY-ONSET CONDUCT PROBLEMS: KEY INGREDIENTS TO IMPLEMENTING THE INCREDIBLE YEARS PROGRAMS WITH FIDELITY

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Over the past 30 years, hundreds of carefully controlled studies for children and youth have established the value of interventions that can reduce behavior problems and delinquency, can improve children's mental health, and can strengthen family functioning (Weisz & Weiss, 1993). Among research-tested psychotherapies, those based on cognitive-social learning methods may have the most support for their effectiveness (Serketich & Dumas, 1996; Taylor & Biglan, 1998), particularly for treating disruptive behaviors in children, including aggression, oppositional defiant disorder and conduct disorder (Chambless & Hollon, 1998; Dumas, 1989; Kazdin, 2002), and attention-deficit/hyperactivity disorder (ADHD; Barkley, 1996). Together these problems represent the majority of referrals for child mental health services (Snyder, 2001).

Despite such compelling evidence, few empirically supported interventions are widely adopted by clinicians or by teachers in community settings

(Kazdin, Bass, Ayers, & Rodgers, 1991; Weisz, Donenberg, Han, & Weiss, 1995). Early adopters who risk implementing evidence-based interventions often face interpersonal, clinical, or organizational challenges that affect their ability to deliver the intervention with fidelity. A clinical innovator might lack the training or skill to deliver a program, might fail to grasp core treatment principles or processes, or might be unable to adapt protocols to individual client circumstances. The organization may have other priorities and fail to support training and supervision. Diluted treatments may be doomed to failure.

It is essential that sound theory and research support new treatment and that procedures are described clearly and are followed closely. In this chapter, I describe the training, supervisory, and organizational requirements to implement the Incredible Years (IY) Training Series, a multifaceted program developed by Carolyn Webster-Stratton at the University of Washington (Seattle) to prevent and to treat early onset of conduct problems in children. I have identified five key elements to effective program implementation:

1. Standardized treatment materials for clinicians and for clients; using comprehensive manuals; well-articulated protocols; videotapes; and books for parents, teachers, and children.
2. Standardized, quality training for clinicians delivering the intervention.
3. Effective peer support, clinical supervision, and consultation for clinicians.
4. Ongoing, fidelity monitoring, including regular, participant evaluation and certification of clinicians and mentors.
5. Agency or administrative support for clinicians.

This chapter provides detailed information about each of these important steps to program implementation with emphasis on supervision. Before describing them, I briefly sketch the components of the intervention program. Detailed descriptions of the theory behind the program development and the therapy process can be found in other reviews (Webster-Stratton, 1998a; Webster-Stratton & Hancock, 1998; Webster-Stratton & Reid, 2004a).

THE INCREDIBLE YEARS TRAINING SERIES: CONTENT, METHODS, PROCESSES, AND RESEARCH

Delivering the program with fidelity means not only offering all the core content components and required number of sessions but also delivering the program using the recommended therapeutic group process and training

methods. In the next section, the core program components will be reviewed as well as recommendations for when additional program supplements may be added to meet the needs of particular families or populations.

The Content and the Use of the Intervention Programs

The core program, entitled BASIC, teaches parents (a) child-directed play and reinforcement skills and (b) specific nonviolent, discipline techniques, including time out, ignoring, logical and natural consequences, and problem-solving strategies. The program starts by focusing on building positive parenting because a strong, positive parent–child relationship is considered to be the foundation for effective discipline. There are preschool and school-age (i.e., up to Grade 4) versions of BASIC, and there are modifications for either a treatment or a prevention focus. There are protocols for a minimum of 12 sessions with video vignettes. However, the program can be extended depending on the group size and the participants' needs. Parents who have neglected their children may need extra sessions on child-directed play to foster more nurturing relationships and may need cognitive and emotional stimulation before learning discipline strategies. Groups using interpreters usually require at least four additional sessions. Parents with extremely difficult children may need three to four extra sessions to develop incentive systems and individual behavior plans. Although protocols suggest time frames for vignettes and for home activities to be completed, the skilled group leader will pace the group according to the participants' learning ability and needs.

There are also additional training program supplements to choose from in order to tailor the program for families with additional goals. A 9- to 12-session ADVANCED program helps parents cope with interpersonal problems and includes training in communication skills, anger management, depression and stress management, problem solving, and ways to give and to get support. For children diagnosed with conduct problems, it is recommended to add the ADVANCED program to the BASIC program, producing a 24- to 26-week protocol. The Supporting Your Child's Education program aids parents in strengthening children's general academic skills and in promoting strong home–school connections. This four-session program can be offered to parents whose children have learning problems or have been diagnosed with ADHD. The Preschool Readiness program is another four-session program that focuses on training parents in social and emotional coaching and in interactive reading skills. This program component can be offered to parents who want to encourage their children's emotional regulation, positive peer relationships, and reading readiness. A 22- to 24-week child-training program, the Dinosaur Curriculum, works to ameliorate factors placing children at risk for behavior problems. It teaches emotional literacy,

social skills, problem solving, and anger management. It can be offered alone or with the parent program. For children with pervasive, behavior problems at home, at school, and with peers, it is recommended that they participate in the Dinosaur Curriculum, while their parents receive training in their program. Lastly, a teacher training program is available to promote teachers' use of (a) tested management and discipline strategies to decrease classroom aggression and to increase social competence and (b) behavior plans developed in collaboration with parents in training (Webster-Stratton & Reid, 2004b). Our research shows that adding either the Dinosaur Curriculum or the Teacher Training to parent training enhances treatment effects for children with pervasive behavior problems. For the purpose of this chapter, I focus on the BASIC program. Supervision issues for BASIC are applicable to the other IY programs.

Intervention, Behavior-Change Methods, and Processes

Because the extent of children's conduct problems far exceeds existing resources for intervention, IY programs are designed for groups with discussions facilitated by trained group leaders, referred to as clinicians or group leaders in this chapter. The group format fosters mutual support and both normalizes and enriches participants' experiences. Interventions rely on Bandura's (1989) self-efficacy and modeling theory, as well as cognitive-social-learning theory and performance-based methods such as behavioral rehearsal and both live and videotape modeling. Video vignettes depict positive adult-child interactions, effective discipline, and prosocial child behavior. They provide a compelling and a congenial learning format for less verbally oriented families. Video vignettes also promote generalization of parenting skills by portraying models from various cultures, as well as by portraying children of different temperaments and developmental levels.

Research

Positive evaluations of the IY programs resulted in their being recommended as model, blueprints, or evidence-based treatment and prevention programs by several review groups (Chambless & Hollon, 1998; Webster-Stratton et al., 2001). The BASIC programs are supported by seven randomized studies of the treatment version by the developer (Webster-Stratton & Reid, 2003) and by three replications by others (Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Spaccarelli, Cotler, & Penman, 1992; Taylor, Schmidt, Pepler, & Hodgins, 1998). There also have been five studies using BASIC as a prevention program with high risk children; two by the developer (Webster-Stratton, 1998b; Webster-Stratton, Reid, & Hammond, 2001)

and three by independent evaluators (Barrera et al., 2002; Gross, Fogg, Webster-Stratton, Garvey, & Grady, 2003; Miller Brotman et al., 2003).

KEY STRATEGIES TO ENHANCE SUCCESSFUL DISSEMINATION AND IMPLEMENTATION

Successful dissemination of the program depends on the successful development of five key strategies focused on quality, standardized training, ongoing technical supervision and consultation, and agency support.

Strategy 1: Standardization of Treatment Materials and Delivery

To ensure fidelity, programs are in an uncomplicated format enabling group leaders to readily learn the required content and skills. Reliance on comprehensive clinician-treatment manuals and on standardized videotapes allows the clinician to focus on facilitating groups, not on memorizing content. Items from the standardized treatment package include books or CDs for the parents, standard weekly home activities, refrigerator magnets and refrigerator notes that summarize key principles, and weekly evaluation forms. Group leaders receive videotape protocols and checklists for each session, a book explaining the program's theory, and a description of the collaborative process for leading groups (Webster-Stratton & Herbert, 1994). A group leaders' manual includes the questions to follow each video vignette, the developer's interpretation of each vignette, and the points for discussion. The manual provides practical guidance on topics ranging from setting up the room for the first session to engaging low-income families to promoting support both within and outside the group (Webster-Stratton & Hancock, 1998).

Strategy 2: Standardized Quality Training Workshops

In addition to detailed materials, standardized training provides clinicians with an introduction to the program content, methods, and group facilitation process. The initial training is offered in a 3-day workshop to small groups of clinicians. Those selected to do the training are certified trainers and mentors who have extensive experience delivering the program and who are exemplary models for demonstrating the therapeutic processes. Videotapes of trainers' actual group sessions allow clinicians to see, and to model, how the trainer works with groups. The trainers also use established performance-based training techniques, including discussion, rehearsal, practice role-playing, brainstorming, values exercises, persuasion techniques, and

homework activities. Such variety addresses different learning styles. These techniques parallel those used in the parent program.

A collaborative approach is essential to the treatment process—and to training group leaders. It is empowering, and it triggers less resistance than didactic or prescriptive approaches. Encouraging participants to identify their own goals and barriers increases their confidence and engagement. Collaboration enhances cultural and developmental sensitivity because participants can apply the program's principles to their own experiences. Collaboration reduces dropouts and leads participants to jointly invest in outcomes (Meichenbaum & Turk, 1987; Seligman, 1990).

Clinician training uses all the methods used with parents. Trainers model the collaborative process, asking clinicians to act as parents, to respond to videotapes, and to enter group discussions, role-playing, and values exercises. After the trainer models group-leader strategies, she invites discussion of the therapeutic and the collaborative strategies used in the role-playing. Because role-playing is frequently resisted, the trainer shows how such practice helps leaders understand the insights of parents. Role-playing and live rehearsal are also used to demonstrate skills and to aid understanding in the peer review and in the supervision that follow initial training.

Clinicians-in-training assess the advantages and the disadvantages of all the techniques, identify goals and barriers for delivering the program, and strategize to overcome them. Finally, they evaluate each workshop as in the actual intervention, and they learn how the trainers use evaluations to tailor workshops and to meet participant's needs.

Strategy 3: Peer Support, Clinician Supervision, and Consultation for Clinicians

From this point forward, I use the word *consultant* for the experienced IY trainer or mentor who continues to support the leader's, or the clinician's, work, unless there is a reason to make a distinction between them. After the initial training, group leaders need adequate time to study the materials, to prepare their sessions, and to arrange logistics (e.g., food or day care). Clinicians may be discouraged or demoralized by particular families and their lack of apparent progress. They may also be discouraged by perceived lack of agency support for their implementation of the program. Weekly peer support and clinician consultation are crucial for first-time group leaders.

Consultation and supervision take several forms and may evolve within an agency. For agencies that are implementing the program for the first time, consultants will be offsite but will begin to establish a relationship with the clinicians. It is recommended that clinicians arrange regular telephone consultations with the IY mentor or trainer and use e-mail to ask about doubts or questions. They are also encouraged to submit a videotape of a

session, midway through their first group (around Session 5), for further feedback. IY mentors and trainers have been trained to supervise (part of the extensive IY Mentor certification process, which is discussed later in this chapter), have extensive experience with the program, and usually have access to equally experienced colleagues or to the program developer. Such consultants are a vital resource to new IY clinicians. After clinicians have completed one or two groups, about 6 to 9 months after training, it is recommended that they participate in a consultation workshop with IY trainers either onsite or at the IY headquarters in Seattle. In these consultation workshops, group leaders come together to share selected portions of their videotapes. Feedback and supervision regarding videotaped sessions can be a huge asset in helping clinicians gain new ways to handle problems that were particularly difficult for them. Reviews of beginner's tapes frequently reveal difficulties with using the videotapes, with doing role-plays, with adhering to protocols, with tailoring the program to bring families' personal problems to life, or with making strategies developmentally appropriate. Initially, clinicians can be preoccupied with the mechanics of videos, manuals, food, or handout preparation rather than with the therapeutic group process. New leaders tend to be less collaborative and tend to be more prescriptive in their approach. Supervision and the peer-review and support processes are there precisely to help improve their group process skills and their response to individual parent or child issues. In supervision, the clinicians' videotapes will serve as the stimulus to trigger a re-enactment of scenarios faced in the groups. Clinicians practice alternative responses to difficult group situations or questions and gain support from their colleagues. The supervision process is nurturing and caring and is focused on the clinician's strengths, as well as on practicing different strategies. With this kind of warmth from the trainer or mentor, group leaders feel supported and empowered to work successfully with their groups.

Weekly peer support and supervision are recommended for any group leader but are crucial for clinicians running a group for the first time. Peer support is key to continued learning and successful intervention, regardless of a clinician's expertise. Often, group leaders become discouraged when a particular family or child fails to progress. Peer group support and the perspective of the supervisor help the leader to maintain optimism and to find approaches for resistant parents or children. It is recommended that clinicians begin videotaping their groups right away and meet weekly with peers for videotape review and for mutual support. It is the policy of the IY program to train groups of clinicians from the same area or agency, so they can participate in the peer-review process. Individuals are not trained to work without a peer support network. It is also the policy that clinicians from the same agency or locale join the peer-review process immediately after training, even if they do not have an active group at the time.

In many ways, the peer-review process can be considered a variation on group supervision. The process and the advantages of group supervision are detailed in two other chapters (7 and 8) in this volume. When group members share their work and offer constructive support, they not only aid each other in conducting IY groups but also empower themselves as thinkers, self-managers, and evaluators. Even in classic group supervision, it is the practice of supervisors to allow group members to maximize their mutual contribution to the supervisory process, to set their own goals, and to intervene only to guide when the group is unable to carry the process or when core principles are not addressed.

The fact that each member of the peer review group has access to an individual IY consultant who critiques their tapes adds greatly to what the members of the peer-review group can offer each other. Consultants model the style of constructive and supportive feedback they would like to see characterized or interchanged in the peer review groups. Peer-review groups use the IY group process checklists to guide members in critiquing their own and others videotaped sessions. Six areas are rated in the group process checklist: (a) group-process skills (e.g., building rapport, encouraging problem solving, reinforcing parents' ideas, and creating a safe accepting atmosphere), (b) leadership skills (e.g., establishing ground rules; structuring an agenda; highlighting key points; preventing sidetracking; encouraging generalization; balancing affective, cognitive, and behavioral discussion and practice; and reviewing homework), (c) relationship-building skills (e.g., validating and supporting parents' feelings, fostering optimism, normalizing problems, and using a collaborative model), (d) leader's knowledge (e.g., providing accurate rationale for principles, knowing what is developmentally appropriate, and understanding and knowing how to explain cognitive-social-learning theory and principles of behavior change), (e) leader methods (e.g., using videotape modeling and roleplaying, using homework and practice, and engaging in brainstorming sessions to identify barriers), and (f) parents' responses (e.g., engaging in asking questions, in problem solving, and in sharing ideas). This peer-review and self-review processes help clinicians set goals for future sessions. The process of individual goal setting enhances clinician's motivation to adhere to the program content, the methods, and the processes. If the peer process has difficulties, members can send a videotape of their group session to an IY consultant for feedback.

Supervision and consultation may be sought initially at a distance from IY trainers, but it is important for agencies to begin right away to identify candidates to become mentors or internal champions and to build their own training and supervision capacity for the future. Successful supervision when a clinician is first adopting a new, evidence-based intervention requires the trainer or mentor to help clinicians recognize their role as change agents. My experience suggests it is best if the clinicians implementing a

new intervention in an agency are eager to do so. Clinicians who decide to implement a new program become innovators in the system. Often called *early adopters*, they are willing to take risks and to try new ideas before they have become well-established interventions in the organization (Rogers, 1995). However, some early adopters are unaware of what it means to be a change agent and do not realize that they must engage in social marketing—being a champion for their new services to families and their professional colleagues—and that they must effectively confront organizational resistance or lack of understanding of their efforts. Consultants need to guide clinicians who assume roles as innovators within their organization.

Strategy 4: Fidelity Monitoring, Including Participant Evaluation and Clinician Certification

Program fidelity—determining if clinicians are adhering to session protocols, key content, and therapeutic process principles—is another aspect of supervision. Many clinicians believe that they can eliminate parts of a mental health intervention or shorten it to be more cost effective. They may even cobble together different programs in a smorgasbord intervention. Training, supervision, and certification help clinicians, and administrators, understand that this approach may dilute or may eliminate the positive effects of the program. Research on children with conduct disorders shows that tested interventions of at least 20 hours in length were more effective than shorter programs. Specific research with the Incredible Years program demonstrates incremental improvement in parent and child behaviors based on the number of sessions attended; parents who attended more than two thirds of the sessions had the most effective outcomes (Baydar, Reid, & Webster-Stratton, 2003). Evidence-based interventions are carefully designed with each session building on a prior session. The recommended number of sessions is considered the minimum sessions needed, and groups may require more depending on their needs and their pace of learning. Supervision helps clinicians know how they can appropriately adapt the program to meet the needs of a particular population. A critical distinction must be made between implementing the core or the foundational elements of the program and stifling clinical flexibility. It is easy for the former to be misconstrued as the latter. In supervision, clinicians are encouraged to discuss their knowledge and experience, so they collaboratively adapt the program to unique, parent goals or to child developmental needs. Clinicians come to understand that the principles that guide the program include being flexible, collaborating with the client in setting the agenda, and having fun, rather than following a precise script to be recited at parents. When clinicians understand this, they realize the program actually encourages the use of their clinical skills and judgment. My experience suggests that clinicians

who continue in the program retain the core elements of the intervention while bringing their clinical creativity to bear in the implementation. Supervision helps clinicians balance pursuit of a particular parent's agenda (possibly unrelated to the day's immediate content) in relation to the group process and issues that are relevant for the entire group.

Clinicians ask group participants to complete evaluations of every group session. These weekly evaluations provide feedback on participants' perceptions of the training. They help the clinician to tailor the program to individual learning needs and to become aware of a parent who may be feeling left out, misunderstood, or resistant to an idea presented in the group. From these evaluations clinicians may learn how participants learn best—through modeling or discussion or practice or reading—and then may adapt family home activities accordingly.

A certification or accreditation process allows clinicians to continue their learning process after the initial training and to recognize those who strive to become more competent group leaders. Requirements for certification include the following: adherence to session protocols; parent attendance; positive weekly and final client evaluations for two complete, 12-week, group interventions each lasting a minimum of 12 weeks; two self- and peer-evaluations for each complete program offered using the peer content and the methods checklists; completion of a 3-day authorized training workshop; and satisfactory review of a complete videotape of a group session by a trainer who rates the clinician's adherence to the program content and methods, as well as the clinician's therapeutic skill in the collaborative process. Satisfactory peer review, videotape, parent evaluations, and group attendance indicate mastery of the content and the therapeutic process necessary for certification. Clinicians who become certified can reasonably anticipate achieving effects similar to those achieved in the published outcome studies evaluating the program.

To maintain program fidelity, certified clinicians are encouraged to attend ongoing consultation and technical support workshops every 2 years and to continue participating in peer-review groups within their agency. Client evaluations and completed session protocols are also part of the clinician's accountability to the agency.

Those chosen to become accredited mentors are certified group leaders with exceptional group leadership skills, mastery of the collaborative process, understanding of the research, and desire to support other leaders. They receive further training in supervision and in delivering the core training workshops. Prospective mentors have their group tapes intensively reviewed, participate in supervision and consultation workshops, and colead training workshops with a certified trainer. When mentors complete training and receive positive workshop evaluations and positive mentor supervision evalu-

ations by participants and trainers, they are accredited to offer training workshops and to supervise within their agency or district. Mentors receive consultation, workshops with other mentors, videotape feedback on workshops, further training, and updates regarding the program.

Strategy 5: Ongoing Training and Support for Agencies to Support Clinicians

No program can be faithfully implemented without agency or organizational support for the clinicians and the intervention. The decision to adopt an evidence-based intervention, such as IY, should reflect a consensus among clinicians and administrators that the choice of treatment model best meets their goals, the agency philosophy, and the needs of their clients. In other words, there is a good innovation–agency–clinician values fit. It may be necessary for administrators to re-adjust clinician job descriptions to recognize the clinicians' time commitments to ongoing training, peer support, supervision, recruiting for and carrying out groups. Even though group approaches are more cost effective than individual approaches, administrators may not understand the time needed to call parents weekly, to assure transportation and food are available, to arrange day care, and to prepare materials for the sessions. Sometimes administrators are surprised to find that the initial training does not prepare their clinicians to start groups the following week. It is imperative that administrators understand that learning a new evidence-based intervention will also involve studying the videotapes and training manuals and meeting in peer-support groups to practice with their colleagues. The administrative staff and internal advocates need to assure that there are plans for ongoing consultation and supervision from the outside trainer. The IY trainer collaborates with the organization's internal advocate, provides consultation to clinicians and administrators regarding program implementation, and anticipates possible resistance and difficulties with the intervention. The trainer is in an excellent position to advise the administrators in ways to support clinicians' change efforts. The IY Agency Readiness Questionnaire can help administrators understand what is needed to support the clinician's training, the clinician's needs for logistical support, and the clinician's ongoing consultation and supervision.

It is best if there is an administrative champion, ideally a trained mentor, within the agency who understands the workings of his or her own organization, as well as the requirements of the new program. Research shows that clinicians, who are left to champion a program without an active administrative champion, quickly burn out from the extra work, resent the lack of support, and often leave the agency (Corrigan, 1995). Research indicates that the interpersonal contact provided by the internal advocate

is a critical ingredient in adoption of new programs (Backer, Liberman, & Kuehnel, 1986). Administrative champions are often more important to the long-term success of the intervention than to the clinicians.

Administrators may select promising clinicians and persuade them to learn this new intervention. The program will attain a strong reputation if it begins with a few enthusiastic leaders rather than if it begins with a mandate that all clinicians adopt the program. Those who are not risk takers, *late adopters*, will venture into new programs only after respected colleagues are successful (Rogers, 1995). Encouraging clinicians who become certified as group leaders to continue and to become certified as mentors builds the infrastructure of a lasting program. At first, the IY trainers provide direct support to the clinician, as detailed in Strategy 3. However, the goal is to make agencies self-sufficient in their ongoing training and in their support of the program. Administrators can also provide important reinforcement to therapists by recognizing and rewarding those who work to become certified and achieve high quality delivery of the program. Reinforcement, both social and tangible, is important to therapists' ongoing commitment and adherence to this program. Moreover, when administrators promote therapist certification as a way of supporting evidence-based practice, therapists appreciate that they are working toward goals and a philosophy that is highly valued by the organization.

CONCLUSION

Implementing a new evidence-based intervention in an agency is not unlike remodeling a house. The architect (i.e., the program developer or trainer) must work closely with the contractors (i.e., the clinicians and administrators) to explain the blueprints and design features, while the contractors assure that building codes are observed and that workers have the expertise to handle the job. Both the architect and the contractor must be aware of the family's needs and desires, as well as their timeline and budget constraints. As the remodeling continues, there will undoubtedly be changes as the family realizes different needs or as discoveries are made (e.g., workers uncover asbestos or termite damage). This will necessitate a collaborative and a flexible approach with open communication and a common spirit of problem solving. In a similar fashion, the clinicians must be carefully selected and well trained, must be provided with supervision and consultation, must work within a supportive infrastructure, and must be bolstered by quality control of the program delivery. Systematic, regular feedback from the clients (i.e., parents, teachers, and children) and the consultants in the process of collaborative discussion and session evaluations assures that the clinician is implementing the program with sensitivity

and with relevance according to the individual family's needs and cultural background and according to the nature of the children's problems.

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